

Wellness First Chiropractic – Pediatric History and Information

Patient Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Sex _____ Date of Birth _____ Age _____ SS# _____

Guardian Name _____ Occupation _____ Employer _____

Employer Address _____ Wk Phone _____ Hm Phone _____

Cell Phone _____ E-mail _____ Guardian Date of Birth _____

Guardian SS# _____ Age _____

Who referred you to our office? _____

Is your visit due to an injury? Yes No If yes, please check: Auto Other

(If this visit is due to an auto injury, please see receptionist for a special injury form)

PREGNANCY AND BIRTH INFORMATION

Place of Birth: Home Birthing Center Hospital Other: _____

Type of Birth: Vaginal C-Section

Procedures: Vacuum Forceps Other: _____

Provider Used: Midwife OB/GYN Other: _____

Labor Medications: None Epidural Pitocin Other: _____

Total Number of Ultrasounds: _____

Was There a Breech Presentation of the Baby: _____

Was Labor Induced: _____ **Drugs Given for Inducing:** _____

DRUG AND NUTRITIONAL INFORMATION

Breastfed: Y / N Length of Time: _____ **Formula Fed:** Y / N Length of Time: _____

Do you vaccinate you child: Y / N **Reason for NOT vaccinating:** Medical Necessity / Personal Belief

Number of vaccinations child has received: _____ **Number that contained Thimersol:** _____

Number of antibiotics child has received in the last 6 months: _____ **Lifetime:** _____

Any Food Allergies: Y / N **Which Foods:** _____

Current prescription or over the counter drugs being taken: _____

SYMPTOMS

- | | | | |
|------------------------------------|---|--------------------------------------|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Sleeping Problems |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Digestive problems | <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Learning Disabilities |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> ADHD | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Other _____ |

Do you have insurance? Yes No If yes, Company _____

I.D.# _____ Policy Group # _____

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered me are charged directly to me and I am personally responsible for payment. It is my understanding that my credit may be checked if Wellness First Chiropractic extends credit to me and I understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and paid unless other arrangements are made. I hereby authorize the doctors at Wellness First Chiropractic and whomever they may designate as their assistants; to administer treatments as they deem necessary and also authorize the release of any information acquired in the course of examination or treatment. I certify that the above information is true and correct.

Patient's (Parent or Guardian's) Signature: _____

Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working together towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it to prevent any confusion and disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments to the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes an alteration of nerve function and interference to the transmission of mental impulses, resulting in the lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provide who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the
(print name)
above statements.

(signature)

(date)

