Pediatric's Health History

CARUSO CHIROPRACTIC CLINIC

We are pleased to welcome you to our practice. To save time and allow us to better serve you, please complete all the information required. If you have any questions, we'll be happy to help.

1. Name (Last, First, Middle Initial) | 2. Social Security # | 3. Age | 4. Date of Birth

5. Sex ☐ M ☐ F | 6. Address City State Zip | 7. Telephone #

8. Name of Father | 9. Any Health Problems | 10. Name of Mother | 11. Any Health Problems

12. # of Brothers & Sisters | 13. Name(s) & Age(s) | 14. Any Health Problems

15. Name of Person Responsible for this Account | 16. Any Health Insurance ☐ Yes Company's Name: ☐ No

17. Any Previous Chiropractic Care ☐ Yes Where? ☐ No | 18. Name, Location & Telephone # of Pediatrician/Family Doctor

19. Birth Weight | 20. Birth Length | 21. Type of Birth ☐ Vaginal (Normal) ☐ Forceps ☐ Breech ☐ Cesarean ☐ At Home ☐ In the Hospital

22. Any Difficulties during Labor/Delivery | 23. Any Difficulties during Pregnancy

24. Referred by | 25. APGAR Score | 26. Quality of Sleep ☐ Good ☐ Fair ☐ Poor | 27. # of Hours of Sleep

28. Vaccinations ☐ Hepatitis B ☐ Polio ☐ Others ☐ DPT ☐ MMR ☐ None | 29. Any Breasfeeding ☐ Yes How Long? ☐ No

30. Has He/She Ever Had Any Accidents, Injuries, or Major Falls? ☐ Yes ☐ No | Month, Year | Type | Describe Injury

31. Has He/She Ever Had Any Surgery? ☐ Yes ☐ No | Month, Year | Type | Describe Injury

32. Is He/She Currently Taking Any Medications or supplements? ☐ Yes ☐ No | Name | Dosage | Reason for Taking It

Current Condition

1. Purpose of the Appointment: Please Briefly Describe the Primary Complaint

2. When Did the Symptoms Begin?

3. Are the Symptoms Getting ☐ Worse ☐ Better ☐ Same

Doctor's Use Only

Health History

Check any of the following conditions that the child has had in his/her life.

- ☐ AIDS/HIV
- ☐ Allergies
- ☐ Anemia
- ☐ Asthma
- ☐ Back Pain
- ☐ Bed Wetting
- ☐ Behavioral Problem
- ☐ Cancer/Tumors
- ☐ Chronic Cough
- ☐ Colic
- ☐ Congenital Anomaly
- ☐ Constipation
- ☐ Diabetes
- ☐ Diarrhea
- ☐ Difficulty Sleeping
- ☐ Digestive Problem
- ☐ Discolored Urine
- ☐ Dizziness/Fainting
- ☐ Earache/Infections
- ☐ Excessive Thirst
- ☐ Eye/Vision Problem
- ☐ Frequent Colds/Flu
- ☐ Genital Problem
- ☐ "Growing Pain"
- ☐ Hayfever
- ☐ Headaches
- ☐ Hearing Problem
- ☐ Heart Problem
- ☐ Hyperactivity
- ☐ Juvenile Arthritis
- ☐ Liver Problem
- ☐ Loss of Taste
- ☐ Lung Problem
- ☐ Measles
- ☐ Mental Problem
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Nausea/Vomiting
- ☐ Neck Pain
- ☐ Smelling Problem
- ☐ Paralysis
- ☐ Pinched Nerve
- ☐ Pneumonia
- ☐ Polio
- ☐ Poor Appetite
- ☐ Rheumatic Fever
- ☐ Rubella
- ☐ Rubeola
- ☐ Seizure/Convulsion
- ☐ Shortness of Breath
- ☐ Sinus Problem
- ☐ Skin Problem
- ☐ Swellings
- ☐ Throat Problem
- ☐ Thyroid Problem
- ☐ Tuberculosis
- ☐ Urinary Problem
- ☐ Walking Problem
- ☐ Whooping Cough

Family History

Check the following family members that had any of the diseases mentioned above.

☐ Father: __________ ☐ Mother: __________ ☐ Uncles/Aunts: ____ ☐ Grandparents: ___

Developmental History

Please tell us at what age did your child

Respond to Sound: ____________________

Follow an Object with Eyes: ____________________

Hold Head up: ____________________

Sit Alone: ____________________

Crawl: ____________________

Stand: ____________________

Walk Alone: ____________________

Talk: ____________________

Authorization & Consent for Treatment and X-ray

I certify that I have read, understood, and answered the above information to the best of my knowledge. I understand that providing incorrect information can be dangerous to my child's health. I authorize Caruso Chiropractic Clinic to release any information concerning this condition to any insurance company, attorney, or health practitioners. I authorize direct payment to you for any sum that I owe now or in the future, from any insurance company that is obligated to reimburse me for charges incurred in your office. A photocopy of this form is acceptable for payment. I agree to be responsible for payment of all services rendered on my behalf or my dependents, and pay it within a 90 day period. X-ray negatives will remain the property of this office, and could be seen at any time while the person is still a patient at this office. I hereby authorize Dr. Sam Caruso, and whomever he may designate as his assistants, to administer treatment to me or my dependents as he so deems necessary.

SIGNATURE OF MINOR'S PARENT OR GUARDIAN WITNESS DATE

Patient Name: ______________________________ Date: ______________

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I am aware of the Caruso Chiropractic Clinic, P.C. Notice of Privacy Practices and if I choose to obtain a written copy I can do so by logging on to www.carusochiropractic.com

X____

Signature of Patient (or parent of minor) **Date**

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Signature of Witness Date