Child'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.

TODAYS DATE:				
1. Name (Last, First, Middle Initial)	2. Sex □ M □ F	3. Social Security #	4. Age	5. Date of Birth
6. Address City State Zip			7. Parent cell phone # & Carrier	
8. Name of School	9. What Grade?	10. Sports & Activities Preformed by patient		
11. Name, Telephone, and Address of Person Responsible for this Account			12. Do you have health insurance? □ YES □ NO Company's Name:	
13. Name of Father	14. Does the Father have any Health Problems?	15. Name of Mother	16. Does the Mother have any Health Problems?	
17. # of Siblings	18. Name(s) & Age(s) of Siblings		19. Do your siblings have any health problems?	
20. Referred by:	21. # of hours sleep a night?	22. Quality of Sleep? □ Good □ Fair □ Poor		
23. Any Difficulties with birth?	24. Any Difficulties after Birth?			
25. Any Previous Chiropractic Care? □ YES □ NO Where?	26. Name, address, & telephone # of Pediatrician/Family Doctor			
26. Have you ever had any accidents, injuries, or major falls? □ YES □ NO	Month, Year	Type	Describe Injury	
27. Have you ever had any surgery? □ YES □ NO	Month, Year	Type	Describe Injury	
28. Are you currently taking any medication? □ YES □ NO	Name	Dosage	Reason for taking it	
29. Are you currently taking any Nutritional Supplements? □ YES □ NO	Name	Dosage	Reason for taking it	

Health History

Check any of the following conditions that the child has had within the last year.

MUSCULO-SKELETAL
- ☐ Arms/Hands Pain
- ☐ Hip Pain
- ☐ Jaw Problems
- ☐ Joints Pain
- ☐ Legs/Feet Pain
- ☐ Low Back Pain
- ☐ Mid Back Pain
- ☐ Neck Pain
- ☐ Shoulder Pain/Tightness
- ☐ Stiffness

NERVOUS
- ☐ Face Twitching
- ☐ Fainting
- ☐ Hyperactivity
- ☐ Numbness/Tingling
- ☐ Pinched Nerve
- ☐ Seizures/Convulsions
- ☐ Tremors

SKIN
- ☐ Skin Problems
- ☐ Tumors/Cysts/Lumps

C-V-R
- ☐ Asthma
- ☐ Chest Pain
- ☐ Chronic Cough
- ☐ Shortness of Breath

GASTRO-INTESTINAL
- ☐ Abdominal Pain/Cramps
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive Thirst
- ☐ Frequent Nausea/Vomiting
- ☐ Heartburns
- ☐ Hemorrhoids
- ☐ Hernia
- ☐ Poor Appetite
- ☐ Ulcers

GENITO-URINARY
- ☐ Bed Wetting
- ☐ Bladder Problems
- ☐ Discolored Urine
- ☐ Gential Problems
- ☐ Painful/Burning urination

EENT
- ☐ Ear/Hearing Problems
- ☐ Ear Infections
- ☐ Eye/Vision Problems
- ☐ Loss of Taste
- ☐ Nose/Smelling Problems
- ☐ Sinus Problems
- ☐ Throat Problems

GENERAL
- ☐ Allergies
- ☐ Behavioral Problems
- ☐ Cold Sweats
- ☐ Depression
- ☐ Dizziness
- ☐ Fatigue
- ☐ Headaches
- ☐ Memory Problems
- ☐ Sudden Loss of Weight
- ☐ Swelling
- ☐ Others: _____

Check any of the following diseases which you have had in your life.

- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Anorexia
- ☐ Bulimia
- ☐ Cancer
- ☐ Chickenpox
- ☐ Colic
- ☐ Congenital Anomalies
- ☐ Diabetes
- ☐ Disc Herniation
- ☐ Hayfever
- ☐ Heart Problems
- ☐ Juvenile Arthritis
- ☐ Kidney Problems
- ☐ Liver Problems
- ☐ Lung Problems
- ☐ Measles
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Paralysis
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic Fever
- ☐ Rubella
- ☐ Rubeola
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Others: _____

Family History

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

- ☐ Father: _____
- ☐ Mother: _____
- ☐ Sister: _____
- ☐ Brother: _____
- ☐ Uncles/Aunts: _____
- ☐ Grandparents: _____

Patient Name: _____ Date: _____

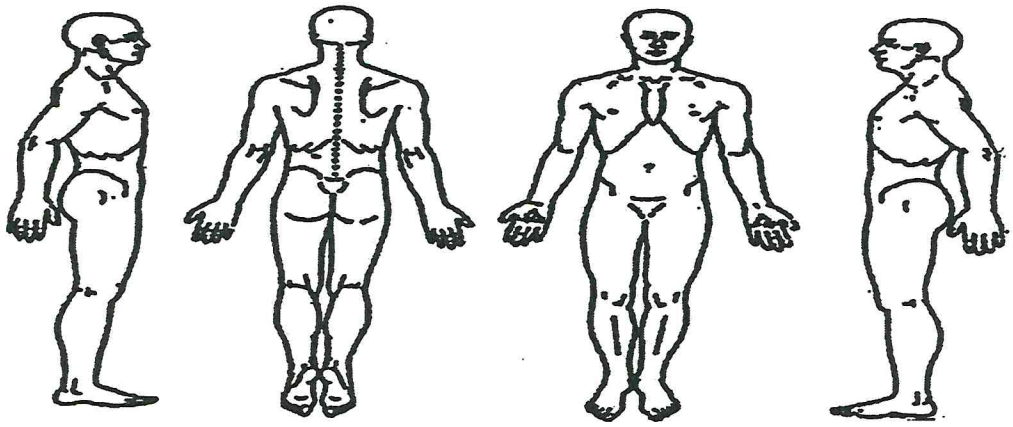
Your Current Condition

Patient Name: _____ Date: _____

1. Chief complaint? _____

2. Is today's problem caused by: □ Auto Accident □ Workman's Compensation □ Other

3. Indicate on the drawings below where you have pain/symptoms



4. How often do you experience your symptoms?

□ Constantly (76-100% of the time) □ Occasionally (26-50% of the time)
□ Frequently (51-75% of the time) □ Intermittently (1-25% of the time)

5. How would you describe the type of pain?

□ Sharp □ Numb
□ Dull □ Tingly
□ Diffuse □ Sharp with motion
□ Achy □ Shooting with motion
□ Burning □ Stabbing with motion
□ Shooting □ Electric like with motion
□ Stiff □ Other:_____

6. How are your symptoms changing with time?

□ Getting Worse □ Staying the Same □ Getting Better

7. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

8. How much has the problem interfered with your work?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

9. How much has the problem interfered with your social activities?

□ Not at all □ A little bit □ Moderately Quite a bit □ Extremely

10. Who else have you seen for your problem?

□ Chiropractor □ Neurologist □ Primary Care Physician
□ ER physician □ Orthopedist □ Other:_____
□ Massage Therapist □ Physical Therapist □ No one

11. How long have you had this problem? _____

12. How do you think your problem began?_____

13. Do you consider this problem to be severe? □ Yes □ Yes, at times □ No

14. What aggravates your problem?_____

15. What alleviates your problem? _____

16. What concerns you the most about your problem; what does it prevent you from doing? _____

Patient Name: _____ Date: _____

17. What is your: Height_____ **Weight** _____

18. How would you rate your overall Health? □ Excellent □ Very Good □ Good □ Fair □ Poor

19. What type of exercise do you do? □ Strenuous □ Moderate □ Light □ None

20. What activities do you do at work?

□ **Sit:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Stand:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Computer work:**	□ Most of the day	□ Half the day	□ A little of the day
□ **On the phone:**	□ Most of the day	□ Half of the day	□ A little of the day

21. What activities do you do outside of work? _____

_____

22. Have you ever been hospitalized? □ No □ Yes
If yes, why _____

23. Primary Care Physician name, phone and address: _____

_____

23. Anything else pertinent to your visit today?_____

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 health.

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

Insurance Company Name _____

Primary Insured Person _____ Primary Insured Date of Birth _____

Primary Insured Gender: □ Male □ Female How is patient related to Primary Insured? _____

Authorization for treatment and billing

I hereby authorize Dr. Sam Caruso & Dr. Bradley Sabo or whichever Dr/ Chiropractic assistant they may designate to administer treatment to me or my dependents they deem necessary.

I authorize Caruso Chiropractic Clinic to release any information concerning my condition to any insurance company, attorney, or health practitioners. I authorize direct payment to Caruso Chiropractic Clinic 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, or my attorney out of the proceeds of my settlement. A photocopy of this form is acceptable for payment. I herby assign and give to Caruso Chiropractic Clinic the right to take action against any insurance company that is obligated by contract to make payment to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for the payment of all services rendered on my behalf or my dependents, and pay it within a 90 day period. I understand that in the event my account is past due, I will be charged and I will be responsible for an additional $20.00 fee.

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

Consent for Release of Information

I understand under the HIPAA guidelines, my personal account and medical information may not be released to anyone without my consent. I am allowing any/all of my account and medical information to be given to the persons named below when requested by the named persons below.

_____

_____

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

_____

Signature of Witness Date