

PEDIATRIC HISTORY FORM

PATIENT DEMOGRAPHICS

HR#: _____

Today's Date ____/____/____

Child's Name _____

Date of Birth ____/____/____ Age: ____

Birth Height: _____ Birth Weight: _____ Current Height: _____ Current Weight: _____

Address _____

City _____ State _____ Zip _____ Phone (Home) _____

Mother's Name: _____ DOB ____/____/____ Mother's Mobile _____

Father's Name: _____ DOB ____/____/____ Father's Mobile _____

Pediatrician/Family MD _____ City/State _____

Last Visit: ____/____/____ Reason for visit: _____

Who is responsible for this bill? _____

Father's Social Security # _____ - _____ - _____ Mother's Social Security # _____ - _____ - _____

Other (please explain): _____

CHILD'S CURRENT PROBLEM:

Purpose of this visit: ____ Wellness Check-up ____ Injury or Accident ____ Other

Please explain: _____

If your child is experiencing Pain/Discomfort please identify where and for how long

1. **When did the** Problem first begin? Date ____/____/____ ____Unknown ____Gradual ____Sudden

2. **Ever had** this problem **before**? ____ No ____Yes If yes, when? _____

3. Any **bowel or bladder** problems since this problem began?: If yes, describe:

4. Have you seen any **other doctors** for this problem? ____No ____Yes If yes, who?

5. How long ago? ____Days ____Weeks ____Months ____Years

6. What were the results of past treatment? _____

7. How is this problem **NOW?**: Rapidly Improving Improving Slowly About the Same

Gradually Worsening On & Off

8. Please list any **medication taken** for this problem: _____

9. Has your child ever sustained an injury playing organized sports? ___ No ___ Yes If yes; please explain:

10. Has your child ever sustained an injury in an auto accident? ___ No ___ Yes If yes; please explain:

HAS YOUR CHILD EVER SUFFERED FROM: *Check all that apply*

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Orthopedic Problems | <input type="checkbox"/> Digestive Disorders | <input type="checkbox"/> Behavioral Problems |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Neck Problems | <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> ADD/ADHD |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Arm Problems | <input type="checkbox"/> Stomach Aches | <input type="checkbox"/> Ruptures/Hernia |
| <input type="checkbox"/> Seizures/Convulsions | <input type="checkbox"/> Leg Problems | <input type="checkbox"/> Reflux | <input type="checkbox"/> Muscle Pain |
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Joint Problems | <input type="checkbox"/> Constipation | <input type="checkbox"/> Growing Pains |
| <input type="checkbox"/> Chronic Earaches | <input type="checkbox"/> Backaches | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Poor Posture | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Walking Trouble |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Anemia | <input type="checkbox"/> Colds/Flu | <input type="checkbox"/> Sleeping Problems |
| <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Colic | <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Fall off swing |
| <input type="checkbox"/> Fall in baby walker | <input type="checkbox"/> Fall from bed or couch | <input type="checkbox"/> Fall from crib | <input type="checkbox"/> Fall down stairs |
| <input type="checkbox"/> Fall off bicycle | <input type="checkbox"/> Fall from high chair | <input type="checkbox"/> Fall off slide | |
| <input type="checkbox"/> Fall from changing table | <input type="checkbox"/> Fall off monkey bars | <input type="checkbox"/> Fall off skateboard/skates | |

Allergies to _____

Other: _____

I understand that I am directly and fully responsible to Pure Chiropractic for all fees associated with chiropractic care my child receives.

The risks associated with exposure to ionization and spinal adjustments have been explained to me to my complete satisfaction, and I have conveyed my understanding of these risks to the doctor. After careful consideration I do hereby request and authorize imaging studies and chiropractic adjustments for the benefit of my minor child for whom I have the legal right to select and authorize health care services on behalf of.

Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other guardian is not required. If my authority to so select and authorize this care should change in any way, I will immediately notify this office.

Parent or Legal Guardian's Signature

Date

Doctor's Signature

Date

ACTIVITIES OF LIFE

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITIES:	EFFECT:			
Carry Children/Groceries	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sit to Stand	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Climb Stairs	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Pet Care	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Extended Computer Use	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Lift Children/Groceries	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Read/Concentrate	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Getting Dressed	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Shaving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sexual Activities	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sleep	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Static Sitting	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Static Standing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Yard work	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Walking	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Washing/Bathing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sweeping/Vacuuming	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Dishes	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Laundry	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Garbage	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Driving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Other: _____	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform

List Prescription & Non-Prescription drugs you take: _____

Patient signature: _____ Today's Date: __/__/__

Continued on next page

REVIEW OF SYSTEMS

Please mark **P** for in the **Past**, **C** for **Currently** have, or **N** for **Never**

- | | | | | |
|---|---|--|---|---|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Pregnant (Now) | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Frequent Colds/Flu | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Impotence/Sexual Dysfun. | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Jaw Pain, TMJ | <input type="checkbox"/> Convulsions/Epilepsy | <input type="checkbox"/> Fainting | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Heart Problem |
| <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Tremors | <input type="checkbox"/> Double Vision | <input type="checkbox"/> Colon Trouble | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Upper Back Pain | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Diarrhea/Constipation | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Pain w/Cough/Sneeze | <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Menopausal Problems | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Foot or Knee Problems | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Menstrual Problem | <input type="checkbox"/> Difficulty Breathing |
| <input type="checkbox"/> Hip Pain | <input type="checkbox"/> Sinus/Drainage Problem | <input type="checkbox"/> Depression | <input type="checkbox"/> PMS | <input type="checkbox"/> Lung Problems |
| <input type="checkbox"/> Back Curvature | <input type="checkbox"/> Swollen/Painful Joints | <input type="checkbox"/> Irritable | <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Kidney Trouble |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Skin Problems | <input type="checkbox"/> Mood Changes | <input type="checkbox"/> Learning Disability | <input type="checkbox"/> Gall Bladder Trouble |
| <input type="checkbox"/> Numb/Tingling arms, hands, fingers | | <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Liver Trouble |
| <input type="checkbox"/> Numb/Tingling legs, feet, toes | | <input type="checkbox"/> Allergies | <input type="checkbox"/> Trouble Sleeping | <input type="checkbox"/> Hepatitis (A,B,C) |

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name _____

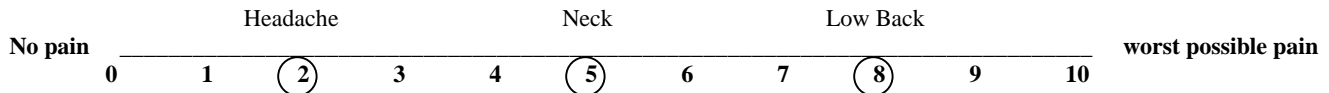
Date _____

Please read carefully:

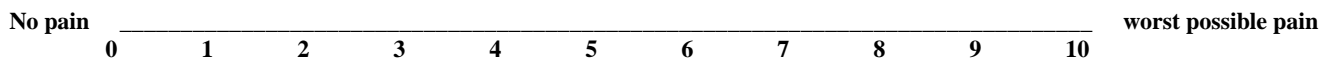
Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

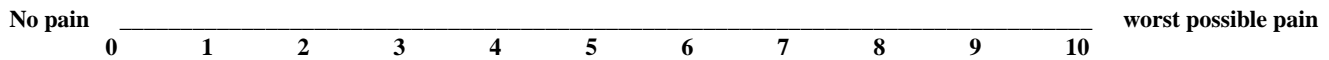
Example:



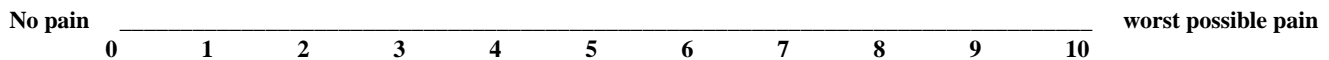
1 – What is your pain RIGHT NOW?



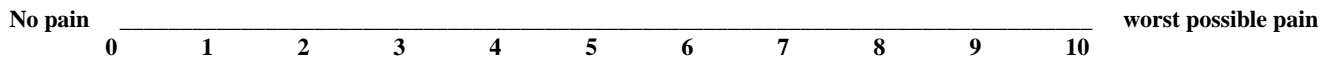
2 – What is your TYPICAL or AVERAGE pain?



3 – What is your pain level AT ITS BEST (How close to “0” does your pain get at its best)?



4 – What is your pain level AT ITS WORST (How close to “10” does your pain get at its worst)?



OTHER COMMENTS:

Examiner _____


Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

Pure Chiropractic Informed Consent

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Pure Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____/_____/____  *Witness Initials*
Patient or Authorized Person's Signature Date


REGARDING: X-rays/Imaging Studies

FEMALES ONLY → *please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.*

The first day of my last menstrual cycle was on ____ - ____ - ____ (Date)

I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____/_____/____  *Witness Initials*
Patient or Authorized Person's Signature Date

Patient Acknowledgment receipt for consent to use and disclosure of Protected Health Information.

Use and disclosure of your Protected Health Information

Your PHI (Protected Health Information) will be used by Pure Chiropractic to authorize and disclose to others for purposes of treatment, obtaining payment, or health care operations of this office.

Notice of Privacy Practices

The undersigned acknowledges receipt of a copy of the current Notice of Privacy Practices for this health care facility. It describes your rights to the limited use of protected health information, including your demographic information.

You have the right to request a restriction or disclosure on the use of your PHI (Protected Health Information). This office may or may not agree to your request.

This office utilizes open or common areas for treatment, however, private areas are available upon request. You may refuse to sign this acknowledgement and authorization and revoke this consent to use PHI. This must be done in writing.

I authorize contact from this office to confirm my appointments, treatment, and billing information by means:

Patient Acknowledgment Contact

- | | | |
|-------------------------------------|---|---------------------------------------|
| <input type="checkbox"/> Cell phone | <input type="checkbox"/> Home phone | <input type="checkbox"/> Text message |
| <input type="checkbox"/> Email | <input type="checkbox"/> All of the above | |

I acknowledge receipt of a copy of the office "Notice of Patient Privacy Policy"

Patient or legal authorized individual signature	Date	
Printed name of Patient		
Sign Guardian of Patient	Relationship	Date

Office use only- As compliance office, attempt to obtain patients signature of this notice was not obtained because:

Signature of Privacy officer

AUTHORIZATION TO CONSENT TO TREATMENT

Dear Parent(s):

State law requires that you consent to most medical treatments for your minor child.

If an adult other than your child's parent or legal guardian accompanies him/her to office visits, we will be unable to provide treatment without your written authorization, except in emergency situations.

To authorize an adult other than your child's parent or legal guardian to consent to medical treatment for your child, please complete the sections below. By completing this authorization, you consent to the sharing of your child's protected health information with this individual as outlined in our Notice of Privacy Practices.

AUTHORIZATION

I, _____ authorize the following individual(s),
(Name of Parent or Legal Guardian)

Name: _____ Relationship to child: _____

Name: _____ Relationship to child: _____

to consent to medical treatment for my minor child/children listed below:

Name: _____ Date of birth: _____

Name: _____ Date of birth: _____

Name: _____ Date of birth: _____

Name: _____ Date of birth: _____

LIMITATIONS

Identify any limitation on the kinds of medical services for which this authorization is given. If none are specified, no limitations will be applied.

Identify any limitations on the time frame for which this authorization is given. If none are specified, no limitations will be applied.

PARENTAL CONTACT INFORMATION

If the nature of the medical care is not routine, please try to contact me (us) regarding the health care of my (our) children at the following telephone number(s). If you are unable for any reason to contact me (us), you may rely on the proxy decision maker for consent.

Parent's Name: _____

Daytime Phone: _____

Evening Phone: _____

Cell Phone: _____

Parent's Name: _____

Daytime Phone: _____

Evening Phone: _____

Cell Phone: _____

Signature of Parent or Legal Guardian

Date