SPINAL PERCEPTIONS CHIROPRACTIC & WELLNESS CHILDREN'S HEALTH HISTORY FORM

Today's Date_____

ABOUT THE CHILD

Name _____ Age _____ Date of Birth _____ /_____ /_____

Gender ❑ M ❑ F Height _____ Weight _____

Home Address _____City _____ State _____ Zip _____

Names and Ages of Siblings_____

Parent(s) Information

Name(s) Mother:_____ Father: _____

Primary Phone (____) _____ Primary Phone (____) _____

Secondary Phone (____) _____ Secondary Phone (____) _____

E-mail _____ E-mail _____

Whom may we thank for referring you to our office? _____

REASON FOR SEEKING CHIROPRACTIC CARE

What concerns do you believe Spinal Perceptions Chiropractic and Wellness can help you with?

_____

Related to: ❑ Sports ❑ Auto ❑ Fall ❑ Chronic ❑ Home Injury ❑ Other _____

When did these symptoms occur?(Date) _____ Or was it gradual? ☐YES ☐ NO

Check any of the following your child has suffered from within the last six months:

__ Ear Infections __Asthma/Allergies __Scoliosis __ADHD __Seizures __Chronic Colds

__Headaches __Recurring Fevers __Digestive Issues __Colic __Temper Tantrum

__Growing/Back Pains __Bed Wetting __Car Accident __ Other:_____

HEALTH CARE PRACTITIONER HISTORY

Has your child ever received chiropractic care? ❑ Y ❑ N Name of D.C. _____

Reason _____ Date of last visit _____

Name of Pediatrician_____ Date of Last Visit_____

Reason for Visit_____

HEALTH, WELLNESS AND CHIROPRACTIC CARE

The information below will help us to see the types of **PHYSICAL, EMOTIONAL & CHEMICAL** stresses your child has been subjected to, how they may relate to his/her present spinal, nerve and health status and whether they may have caused **Vertebral Subluxations** to occur.

PREGNANCY & BIRTH

During pregnancy, did the mother:
❑ Experience any significant illnesses, difficulties, or trauma? _____
❑ Take any drugs/medications? _____
❑ Smoke or consume alcohol

❑ Home birth ❑ Hospital birth ❑ Vaginal ❑ Water birth ❑ Caesarean

Was the delivery premature? ❑ No ❑ Yes Weeks _____Weight _____

Was the baby breastfed? ❑ No ❑ Yes For how long? _____

CHEMICAL STRESS

Chemical stresses can occur when a substance that is toxic to the body is breathed, injected, taken by mouth, or comes into contact with the skin. The following will reveal exposures your child may have experienced.

Please check all that apply and give any necessary details:
❑ Child exposed to second hand smoke
❑ Has taken antibiotics, How much within the last 6 months_____
❑ Currently taking medication _____
❑ Currently taking supplements _____
❑ Vaccination History_____

PHYSICAL STRESS: INFANCY & CHILDHOOD

❑ Has been hospitalized _____
❑ Has had surgery _____

What physical activities does your child participate in? _____

EMOTIONAL STRESS

It is difficult to separate the emotional stress in our life from the physical response that often occurs. Please indicate if your child has ever or is currently experiencing any of the emotional stresses below:

❑ Academic pressure	❑ Loss of a loved one	❑ Bullying	❑ Relocation
❑ Lifestyle change	❑ Parents' divorce	❑ Loss of a pet	❑ New sibling

Does your child have difficulty interacting with schoolmates or friends? ❑ Yes ❑ No
Have you or anyone else noticed that your child is nervous, twitches, shakes, or exhibits rocking behavior? ❑ Yes ❑ No

EXPECTATIONS OF CARE

I would like my child to experience the following benefits from Chiropractic Care:

Check all that apply

- ❑ Symptomatic relief of pain or discomfort
- ❑ Correction of the cause of the problem as well as relief of symptoms
- ❑ Prevention of future problems
- ❑ Healthier spine and nerve system
- ❑ Optimal health on all levels
- ❑ OTHER_____

PLEASE READ AND SIGN

1. I have been informed that a copy of Spinal Perceptions Chiropractic and Wellness Center *"Notice of Privacy Practices for Protected Health Information (HIPAA)"* brochure is available for my review. _____ (initial)
2. I consent to receive communication from Spinal Perceptions Chiropractic and Wellness Center via phone and voicemail postal mail in connection with my care. _____ (initial)
3. Once per month, we host a free wellness seminar (Shop with the Doc, Recipe Day, Mommy and Me Class etc) and publish a newsletter. By initialing below, you consent to receiving a monthly newsletter notification. You may opt out at any time. _____ (initial)
4. I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. I also understand that if care is suspended or terminated, any fees for professional services rendered will become immediately due and payable. _____ (initial)
5. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and policyholder. I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. I hereby authorize assignment of insurance rights and benefits (if applicable) directly to the provider for services rendered to my child. _____ (initial)

The information I have provided on this case history form is true and accurate to the best of my knowledge.
I give Dr. Marquetta Giles DC permission to render care to my child today. This initial visit includes a health history consultation, chiropractic exam and evaluation and any initial care that is determined to be clinically necessary and mutually agreed upon.

Child's Name: (Printed) _____

Parent or Legal Guardian's Name:

(Printed)_____

Signature _____ Date: _____

Thank you for choosing Spinal Perceptions Chiropractic and Wellness Center.

We look forward to helping you.