SCHLUTER CHIROPRACTIC

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# Pediatric Patient Form

## CONFIDENTIAL HEALTH INFORMATION

Please allow our staff to photocopy your driver's license and insurance details. All information you supply is confidential
We comply with all federal privacy standards. Please print clearly.

**PERSONAL INFORMATION:**

_____
Today's Date (MM/DD/YYYY)

_____ _____ _____ _____
Child's Name (Last) (First) (MI) What Does Your Child Prefer To Be Called

_____ _____ _____ Gender _____
Birth Date (MM/DD/YYYY) Age Social Security Number ☐ Male ☐ Female # of siblings

_____ _____
Mother's Name Father's Name

_____ _____ _____ _____
Address City State ZIP Code

_____ _____ _____
Home Phone Mother's Work/Cell Phone Father's Work/Cell Phone

_____ _____
Mother's Email Father's Email

_____
Whom May We Thank For Referring You?

_____ _____
Pediatrician/Family MD Phone

Have you consulted a Medical Physician for this condition?
☐ Yes ☐ No

When?_____ If so, whom? _____ Result _____

**INSURANCE INFORMATION:**

☐ Not Applicable ☐ See Insurance Card Copy

_____ _____ Who carries this policy?
Insurance Carrier (please inform front desk of secondary insurance source) Phone ☐ Self ☐ Spouse ☐ Parent

_____ _____ _____ _____
Insurance Carrier Address City State ZIP Code

_____ _____ _____
Insured's Name (Last) (First) (MI) ID Number Policy/Group Number

_____ _____
Relation to Patient Birth Date (MM/DD/YYYY)

_____ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered.
Initials I fully understand I am solely responsible for any balance not paid by my insurance company.

CASE HISTORY:

Reason for this visit:_____

_____

Child's Congenital Anomalies/Defects:_____

Family History of Congenital Anomalies/Defects:_____

Type of Birth
☐ Normal Vaginal ☐ Cesarean ☐ Forceps ☐ Breech

Birthing Location
☐ Home Birth ☐ Birthing Center ☐ Hospital

Pregnancy History / Problems During Pregnancy:_____

_____

Delivery & Birth History / Problems During Labor & Delivery:_____

_____

| Birth Weight | Current Weight | Birth Length | Current Length | APGAR Scores | Presence at birth of: |
|---|---|---|---|---|---|
| _____ | _____ | _____ | _____ | _____ _____ | ☐ Jaundice ☐ Cyanosis |

Infant Feeding: ☐ Breast # of Months:_____
☐ Bottle # of Months:_____
☐ Formula # of Months:_____
Brand(s):_____

Number of hours of sleep per night:_____

Quality of sleep
☐ Good ☐ Fair ☐ Poor

Immunization History:_____

Has this child ever suffered from: (check all that apply)

| | | | |
|---|---|---|---|
| ☐ Chicken Pox | ☐ Poor Appetite | ☐ Tuberculosis | ☐ Asthma |
| ☐ Measles | ☐ Paralysis | ☐ Headaches | ☐ Sinus Trouble |
| ☐ Rebeola | ☐ Cold/Flu | ☐ Hyperactivity | ☐ Walking Problems |
| ☐ Mumps | ☐ Bed Wetting | ☐ Convulsions | ☐ Muscle Jerking |
| ☐ Rubella | ☐ Digestive Disorders | ☐ Rheumatic Fever | ☐ Ear Aches/Infections |
| ☐ Whooping Cough | ☐ Fainting | ☐ Arm Problems | ☐ "Growing Pains |
| ☐ Dizziness | ☐ Neck Problems | ☐ Leg Problems | ☐ Allergies |
| ☐ Diabetes | ☐ Joint Problems | ☐ Ruptures/Hernias | ☐ Constipation |
| ☐ Arthritis | ☐ Backaches | ☐ Blood Disorders | ☐ Diarrhea |
| ☐ Neuritis | ☐ Broken Bones | ☐ Heart Trouble | ☐ Behavioral Problems |
| ☐ Anemia | ☐ Stomach Aches | ☐ Hypertension | ☐ Other: _____ |

_____

Surgeries:_____ Accidents:_____ Medications:_____

_____
Patient Name

Consultation Notes:

AUTHORIZATION FOR CARE OF A MINOR:

Chiropractic examination and therapeutic procedures including but not limited to spinal adjustments, intersegmental traction, ice application, electrotherapy, and manual muscle therapy are considered safe and effective methods of care. Any procedure intended to help may have complications. While the chances of experiencing complications are small it is the practice of this clinic to inform our patients about them. These complications include, but are not limited to, soreness, inflammation, soft tissue injury, dizziness, and temporary worsening of symptoms. More serious complications are extremely rare. Additional information on side-effects and complications may be available upon request.

I have read and understand the above statements regarding treatment side effects. I also understand that there is no guarantee or warranty for a specific cure or result.

I HEREBY AUTHORIZE SCHLUTER CHIROPRACTIC PC AND ITS DOCTOR(S) TO ADMINISTER CARE AS THEY DEEM NECESSARY FOR MY CHILD/WARD.

_____ _____ _____
Parent/Guardian Signature | Relationsip to patient | Date (MM/DD/YYYY)