Koelling Family Chiropractic • 621 Commons Drive • Fulton, MO 65251 • phone 573.642.2273 • fax 573.642.1900

Pediatric Health History

Child's Name:______________________________________Date:_______________Account#:___________

Address:____City_____________________________________

Child's SS#_____________________________Family Email Address:________________________________

Purpose of this appointment:____

Mother's Name:_________________________________ Phone#:(H)______________(W)______________

Employer:______________________________________ Occupation:______________________________

Father's Name:_________________________________ Phone#:(H)______________(W)______________

Employer:______________________________________ Occupation:______________________________

Legal Guardian:_________________________________ Relationship to child:_______________________

Age (years)_______(months)_______ Date of Birth___/____/____ Sex: Male Female

Siblings and ages:____

Birth Weight:_________ Birth Length______ Present Weight:________ Present Length/ Height:_________

Was the birth: normal vaginal cesarean breech forceps vacuum extraction

home birth birthing center_____________________ hospital_______________________

Pregnancy problems:____

Labor or Delivery problems:____

Congenital defects/ anomalies:____________________________________APGAR scores:_______________

Was there present at birth: meconium (black/green infant feces) cyanosis (blue/ lack of oxygen) jaundice (yellow)

Obstetrician/ Midwife:______________________________Address:_____________________________________

Pediatrician/ Family MD:___________________________Address:_____________________________________

Has this child had vaccinations: Yes No; If so, please list dates:

Hep B__________ OPV__________ DTP__________ MMR__________ HIB__________ VAR__________

Other vaccinations:____

Has this child had any of the following childhood "diseases;" if so, please list dates:

Measles_____________ Chicken Pox____________ Whooping Cough____________ Mumps_____________

Other____

Date and purpose of last Medical Doctor visit:____

Has this child been treated for an emergency? Yes No; Please describe:______________________________

____

Please turn over and complete the other side.

Surgeries:____

Medications:____

if antibiotics, how many rounds/ dosages total since childbirth:_______________________________

Accidents:____

Allergies	Colic	"Growing pains"	Orthopedic problem(s)
Anemia	Constipation	Headaches	Paralysis
Arm problems	Convulsions	Heart trouble	Poor appetite
Arthritis	Diabetes	Hyperactivity	Rheumatic fever
Asthma	Diarrhea	Hypertension	Ruptures/ hernias
Backaches	Digestion problems	Joint problems	Sinus trouble
Bed wetting	Dizziness	Leg problems	Sugar levels (high/ low)
Behavior problems	Earaches	Muscle jerking	Tuberculosis
Broken bones	Ear infections	Neck problems	Walking problems
Colds/ Flu	Fainting	Neuritis	

Has this child ever suffered with any of the following:

Overall, how would you rate the health of this child since birth:_____________________________________

____

Is there anything else we should know about this child?____

____

Diet:____

PERSONAL INJURY ONLY:

Was this child injured in an automobile accident? Yes No; Please explain:_____________________________

____

Was this child riding in a car seat? Yes No; If no, please explain:__________________________________

Was this child in a booster seat? Yes No

Was the car seat/ booster seat in the FRONT or the REAR seat (LEFT / CENTER / RIGHT) facing FORWARD or BACKWARD?

Was this child struck by an air bag? Yes No

Was the vehicle struck from the REAR/ FRONT/ LEFT/ RIGHT side?

List any visible bumps, bruises, cuts, etc. on this child that were caused by this accident.____________________

____

____

I CERTIFY THAT THE INFORMATION ON THIS FORM IS TRUE TO THE BEST OF MY KNOWLEDGE.

____

Signature of Parent/ Legal Guardian Date

Name____Account #__________________

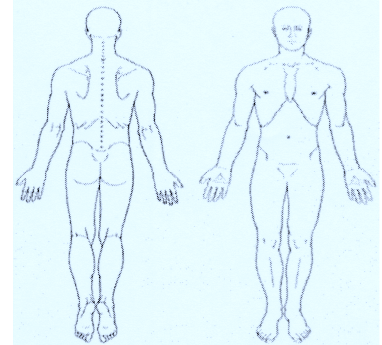
1- Please describe the **condition(s)** that brought you to this office, beginning with your highest **priority** (A) to lowest (C). If you have no health concerns please write "wellness checkup."

A____

B____

C____

Please mark where you have your symptoms.



2- Circle the severity of your problem 1 = No Pain 10 = Very Severe

Neck	right - left - both	1 2 3 4 5 6 7 8 9 10
Mid Back	right - left - both	1 2 3 4 5 6 7 8 9 10
Low Back	right - left - both	1 2 3 4 5 6 7 8 9 10
Arms	right - left - both	1 2 3 4 5 6 7 8 9 10
Legs	right - left - both	1 2 3 4 5 6 7 8 9 10
Other______________________		1 2 3 4 5 6 7 8 9 10

3- **Circle** the **sensations** you are experiencing. Sharp Pain - Burning - Dull Pain - Tingling - Throbbing - Cramping - Numbness - Stiffness - Aching - Swelling - Shooting - Stabbing

4- How **often** do you experience your problem? Constantly - 75% time - 50% time - Less than 25%

5- What **date** & **how** did your problem begin?____

6- Did this result from an **injury** or accident at: home - work - car accident - other - no injury

7- Has your **condition**: improved - gotten worse - stayed the same

8- What makes your problem **worse**: walking - standing - sitting - movement - twisting - lifting - sneezing – coughing - bending - lying – other:____

9- What makes your problem **better**? ____

10- Have you had this **before**? No - Yes when:_______________ Treated by whom?_______________

11- **What** treatment did you receive? _______________________ Date last treated:________________

12- **Results** of previous treatment: good - poor - comments:____________________________________

13- What is this problem **interfering** with: work - sleep - daily routine - recreation - other:__________

14- What do you believe is **wrong** with you?____

15- Name of last **Chiropractor** who treated you:____

Date you were last seen:__________________

16- Name of last **MD or DO** who treated you:____

Date you were last seen:__________________

17- **Females:** Is there any possibility that you are **pregnant**? No - Yes Date of last cycle:__________

18- **Other** health related **information** we should be aware of:

Signature____ Today's Date:___________

I certify that the above information is accurate to the best of my knowledge.

- CONSENT FOR TREATMENT -

I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician(s). I understand and agree that <u>all x-rays and medical records remain the property of this clinic and will be maintained in this clinic up to seven years</u>. If coordination of care is needed, **we will gladly send them to the requesting doctor for you**. If you lapse in your care for an extended period of time, or have new accidents or changes in your health status, <u>additional examinations may be required to update your history</u> and health status before further care can continue. It will be determined by the doctor at that time. The **<u>primary practice objective</u>** of this office is to help restore **HEALTH** by reducing **SUBLUXATIONS** with chiropractic **ADJUSTMENTS. We do not diagnose or treat any disease or condition other than subluxations (spinal and extremities.)** If, however, during the course of chiropractic care we encounter non-chiropractic or unusual findings, we will recommend that you seek the services of a health care provider who specializes in that area.

- RELEASE OF INFORMATION -

We want you to know how your **Patient Health Information** is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the **HIPAA NOTICE** that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care.
2. If there is anyone you do not want to receive your medical records, please inform our office.
3. For your security and right to privacy, all staff have been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this clinic to assure that your records are not easily available to those who do not need them.

- FEMALE PATIENTS ONLY-

By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected at this time. The approximate date of my last menstrual period was ______

- ASSIGNMENT OF BENEFITS -

I hereby instruct and direct the payment of all professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy to **Koelling Family Chiropractic, PC** as payment for professional services rendered.

- BILLING INFORMATION -

Your insurance policy is a contract between you and your carrier. Many policies reimburse for at least some chiropractic care. But coverage varies from policy to policy, and constantly changes. You understand and agree that you are responsible for all charges not paid by your insurance company. Our goal is to help you get well and stay well. We ask you pay at the time of service, **including Medicare patients. We will file your visit to Medicare and <u>Medicare will reimburse you</u>. Our fees are already reduced by Medicare and we do not accept assignment from them. We do not expect them to be sending payment to our office.**

<u>Your signature indicates that you accept financial responsibility for your care, and you are instructing this office to deliver the care that, in our judgment, can best help you in the restoration of your health.</u>

Print Your Name____

Signature ____**Date**____________