

CONFIDENTIAL PEDIATRIC HISTORY FORM

It is our pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To better serve you, please complete the following information. We look forward to working with you! Thank You!

Patient Information

Date _____		Date of Birth _____	
Legal Name: First _____	Middle _____	Last _____	
Preferred Name: First _____	Middle _____	Last _____	
Gender at birth <input type="radio"/> F <input type="radio"/> M	Height _____	Weight _____	
Name of Parent(s)/Guardian(s) _____			
Home # _____	Cell # _____	Work # _____	
Address _____			
City _____		State _____	Zip _____
Patient Email _____			
Emergency Contact _____		Emergency Relation _____	Emergency # _____

How Did You Hear About Us?

<input type="radio"/> Current TWW Patient	Patient Name _____
<input type="radio"/> Social Media	Which Platform _____
<input type="radio"/> Other	_____

Employment Information

Employed <input type="radio"/> Yes <input type="radio"/> No	Employer Name _____		
Employer Address _____			
Employer City _____	Employer State _____	Employer Zip _____	
Occupation _____	Work Supervisor _____	Supervisor # _____	
Work Duties _____			



Patient Name _____

Reason for this visit

Describe the reason for this visit

When did this concern begin? _____ Has this concern Gotten Worse Stayed Constant Comes and Goes

Does this concern interfere with? Work Sleep Daily Routine Other Activities

Briefly Explain _____

Has this concern occurred before? Yes No Briefly Explain _____

Have you seen other doctors for this concern? Yes No

Type of treatment _____

Did an Injury Occur? If yes, complete the following

Work Automobile Home Other Injury Date _____

Injury Origin _____

Describe Discomfort _____

Information Regarding Your Concern

Interfere w/ Activities Yes No Affected Sleep Yes No Frequency _____

Missed Work Yes No Unable to work from _____ Unable to work until _____

Affected Appetite Yes No Explain _____

Reduced Work Yes No Explain _____

Does it Worsen Yes No Explain _____

Weather Affects it Yes No Explain _____

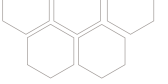
What Aggravates Condition _____

What Improves Condition _____

Received Treatment Yes No Explain _____

X-rays Taken Yes No Explain _____

Pain Level Rating (Scale 1-10, 10 being worst) At its best _____ At its worst _____ Current Level _____



Patient Name _____

For cycling females only

Age of first period _____

Are you pregnant? Yes No

Are you nursing? Yes No

Are you taking birth control? Yes No If yes, which one? _____

Do you have regular cycles? Yes No Menses frequency _____ Length of cycle _____

Do you have missed periods? Yes No

Do you experience painful periods? Yes No

Do you have clotting? Yes No

Are you menopausal? Yes No

Do you have breast implants? Yes No

How many pregnancies have you had? _____

Have you had any miscarriages? Yes No If yes, How many? _____

How many living children do you have? _____

Social Activity Information

Alcohol <input type="radio"/> Daily <input type="radio"/> Weekly <input type="radio"/> Occasionally <input type="radio"/> Never	Caffeine <input type="radio"/> Daily <input type="radio"/> Weekly <input type="radio"/> Occasionally <input type="radio"/> Never
Diet Food Products <input type="radio"/> Daily <input type="radio"/> Weekly <input type="radio"/> Occasionally <input type="radio"/> Never	Drugs <input type="radio"/> Daily <input type="radio"/> Weekly <input type="radio"/> Occasionally <input type="radio"/> Never
OTC Stimulants <input type="radio"/> Daily <input type="radio"/> Weekly <input type="radio"/> Occasionally <input type="radio"/> Never	Exercise <input type="radio"/> Daily <input type="radio"/> Weekly <input type="radio"/> Occasionally <input type="radio"/> Never
Homemade Food <input type="radio"/> Daily <input type="radio"/> Weekly <input type="radio"/> Occasionally <input type="radio"/> Never	Processed Food <input type="radio"/> Daily <input type="radio"/> Weekly <input type="radio"/> Occasionally <input type="radio"/> Never
Soft Drinks <input type="radio"/> Daily <input type="radio"/> Weekly <input type="radio"/> Occasionally <input type="radio"/> Never	Tobacco <input type="radio"/> Daily <input type="radio"/> Weekly <input type="radio"/> Occasionally <input type="radio"/> Never
Water <input type="radio"/> Daily <input type="radio"/> Weekly <input type="radio"/> Occasionally <input type="radio"/> Never	



Patient Name _____

Patient Health History

Previous Chiropractic Care Yes No Date of Last Adjustment _____

Reason _____

Last Physical Exam _____ Primary Physician _____ Physician Phone _____

Physician City _____ Physician State _____ Physician Zip _____

Health Conditions _____

Broken Bones Yes No Treatment Yes No Explain _____

Sprains/Strains Yes No Treatment Yes No Explain _____

Hospitalized Yes No Explain _____

Surgery Yes No Explain _____

Auto Accident Yes No Explain _____

Struck Unconscious Yes No Explain _____

Eating Disorder Yes No Explain _____

Stroke Yes No Explain _____

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e. a bed, changing table, down stairs, etc.). Was this the case with your child? Yes No If yes, please explain _____

Is/has your child been involved in any high impact or contact sports (i.e. soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.). Yes No If Yes, Please list _____

Patient Medications/Vaccinations/Supplements:

Current Medications (prescribed or over-the-counter) _____

Number of doses of antibiotics your child has taken

During the past six months _____ Total during his/her life _____

Vaccination history _____

Vaccine reactions or side effects _____

Current supplements _____



Patient Name _____

Patient Health History (continued)

- | | | |
|---|--|---|
| <input type="radio"/> ADHD | <input type="radio"/> Diagnosed Emotional/Mental | <input type="radio"/> Nosebleeds |
| <input type="radio"/> Alcoholism | <input type="radio"/> Digestion Problems | <input type="radio"/> Pacemaker |
| <input type="radio"/> Allergies | <input type="radio"/> Dizziness | <input type="radio"/> Parkinson's |
| <input type="radio"/> Anemia | <input type="radio"/> Ear Infections | <input type="radio"/> Polio |
| <input type="radio"/> Arteriosclerosis | <input type="radio"/> Epilepsy | <input type="radio"/> Poor Posture |
| <input type="radio"/> Arthritis | <input type="radio"/> Excessive Menstruation | <input type="radio"/> Prostate Trouble |
| <input type="radio"/> Asthma | <input type="radio"/> Eye Pain or Difficulties | <input type="radio"/> Reflux |
| <input type="radio"/> Autoimmune Disease:
_____ | <input type="radio"/> Fatigue | <input type="radio"/> Recurring Fevers |
| | <input type="radio"/> Frequent Urination | <input type="radio"/> Retinal Disease |
| <input type="radio"/> Back Pain | <input type="radio"/> Gallbladder Disease/Stones | <input type="radio"/> Rubella |
| <input type="radio"/> Bed Wetting | <input type="radio"/> Glaucoma | <input type="radio"/> Sciatica |
| <input type="radio"/> Bleeding Disorders | <input type="radio"/> Gout | <input type="radio"/> Scoliosis |
| <input type="radio"/> Breast Lump | <input type="radio"/> Growing Pains | <input type="radio"/> Seizures |
| <input type="radio"/> Bronchitis | <input type="radio"/> Headache | <input type="radio"/> Shortness of Breath |
| <input type="radio"/> Bruise Easily | <input type="radio"/> Hemorrhoids | <input type="radio"/> Sinus Infection |
| <input type="radio"/> Bypass Surgery | <input type="radio"/> Hormone Replacement | <input type="radio"/> Skin Sensitivity |
| <input type="radio"/> Cancer | <input type="radio"/> Hot Flashes | <input type="radio"/> Sleep Problems/Insomnia |
| <input type="radio"/> Cataracts | <input type="radio"/> Hypertension | <input type="radio"/> Smoker |
| <input type="radio"/> Chest Pain | <input type="radio"/> Irregular Heart Beat | <input type="radio"/> Spinal Curvatures |
| <input type="radio"/> Chicken Pox | <input type="radio"/> Irregular Menstrual Cycle | <input type="radio"/> Stroke |
| <input type="radio"/> Chronic Colds | <input type="radio"/> Irritable Bowel Syndrome (IBS) | <input type="radio"/> Swelling of Ankles |
| <input type="radio"/> Cold Extremities | <input type="radio"/> Kidney Infection | <input type="radio"/> Swollen Joints |
| <input type="radio"/> Colic | <input type="radio"/> Kidney Stones | <input type="radio"/> Temper Tantrums |
| <input type="radio"/> Congestive Heart Failure | <input type="radio"/> Liver Disease/Cirrhosis | <input type="radio"/> Thyroid Condition |
| <input type="radio"/> Constipation | <input type="radio"/> Loss of Balance | <input type="radio"/> Tuberculosis |
| <input type="radio"/> COPD/Emphysema | <input type="radio"/> Loss of Memory | <input type="radio"/> Ulcers |
| <input type="radio"/> Coronary Artery Disease | <input type="radio"/> Loss of Smell | <input type="radio"/> Varicose Veins |
| <input type="radio"/> Cramps | <input type="radio"/> Loss of Taste | <input type="radio"/> Venereal Disease |
| <input type="radio"/> CVA (Stroke/Transient Ischemic Attack) | <input type="radio"/> Lung Disease | <input type="radio"/> Whooping Cough |
| <input type="radio"/> Dementia/Alzheimer's | <input type="radio"/> Macular Degeneration | <input type="radio"/> Other: _____ |
| <input type="radio"/> Depression | <input type="radio"/> Measles (Rubeola) | _____ |
| <input type="radio"/> Diabetes | <input type="radio"/> Migraines | _____ |
| <input type="radio"/> Type I <input type="radio"/> Type II <input type="radio"/> Juvenile | <input type="radio"/> Myocardial Infarction (Heart Attack) | |



Patient Name _____

Patient Birth & Feeding History

Name of obstetrician/midwife _____ Pediatrician / Family MD _____

Did patient's mother...

Have ultrasounds during pregnancy? Yes No If yes, how many? _____

Have medications during pregnancy/delivery? Yes No If yes, please list _____

Use cigarettes or alcohol during pregnancy? Yes No If yes, how much and how often? _____

Have birth intervention? Forceps Vacuum extraction Caesarian section

Have an emergency or planned delivery? Yes No

Was patient breastfed Yes No If yes, how long? _____

Was patient formula-fed Yes No If yes, how long? _____

Introduced to solids at ____ months. Cow's milk at ____ months.

Food/juice allergies or tolerances Yes No If yes, please list _____

Other allergies or tolerances Yes No If yes, please list: _____

Number of hours sleeping per night _____ Quality of sleep: Good Fair Poor

Family Health History

Mother Living Deceased Cause of Death _____

Maternal Grandmother Living Deceased Cause of Death _____

Maternal Grandfather Living Deceased Cause of Death _____

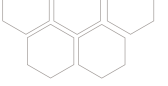
Father Living Deceased Cause of Death _____

Paternal Grandmother Living Deceased Cause of Death _____

Paternal Grandfather Living Deceased Cause of Death _____

Insurance Information

Please provide a copy of your driver's license and insurance card(s).



Patient Name _____

Terms of Acceptance

I certify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to The Wellness Way Clinics. I authorize The Wellness Way and it's staff to examine and deliver care as they see fit. I thereby authorize The Wellness Way to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. Verifying insurance benefits does not guarantee payment from my insurance company. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that there is a 48 business hour cancellation policy for new patient and consultation appointments. Failure to comply with the cancellation policy may result in additional charges. A \$25 fee will be applied to all NSF checks. By signing below, I agree to the financial policy described above and will adhere to all of it's practices.

Signature _____

Date _____