HERITAGE
SPINAL CARE

New Patient Information
PEDIATRIC

Today's date:

Please complete the following information

Child's name:

Parent's name:

Address:

Home number:

Work number:

Where do you prefer we call?

Birth date:

Previous chiropractor:

Birth history

Labor and Delivery: ☐ Easy ☐ Moderate ☐ Difficult

Type of delivery: ☐ Vaginal delivery ☐ C-section ☐ Forceps/vacuum extraction

Regarding your child today

	Yes	No
Is your child accident prone?	☐	☐
Has your child had any falls down steps?	☐	☐
Has your child ever been involved in a motor vehicle accident?	☐	☐
Has your child ever been hospitalized or had surgery?	☐	☐
Has your child ever had any broken bones or sprain injuries?	☐	☐

How does this affect your child's life?

☐ Restricted in daily activities ☐ Excessive appetite or thirst

☐ Hindering ability to exercise or to participate in sports and activities

☐ Poor posture during reading, watching TV, working on a computer

How long has your child been living this way? Weeks Months Years

Would you like to find the cause of your child's problem(s)?

☐ Yes ☐ No ☐ Maybe

If so, what results would you want for your child?

Does your child experience any of these health problems?

☐ Headaches	☐ Learning disorder	☐ Ear infections	☐ Ear problems
☐ Menstrual problems	☐ Breathing problems	☐ Irritability	☐ Sinus pain/allergies
☐ Sleeping problems	☐ Underactive	☐ Asthma	☐ Eating disorder
☐ Fatigue	☐ Stomach problems	☐ Digestive trouble	☐ Hyperactivity
☐ Frequent colds	☐ Frequent flus	☐ Scoliosis	☐ Acne/rashes
☐ Diarrhea	☐ Constipation		

Current health problems:

Currently taking medications:

I understand and agree that health insurance is an agreement between the carrier and myself. I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate care, any fees for professional services rendered to me will be immediately due and payable.

Parent or guardian signature authorizing care

Parent/guardian signature:

Date:

Social security number:

Acknowledgement of HIPPA Privacy Act

My signature acknowledges I have read and understand the HIPPA Act.

Signature: Date:

Personal representative name printed:

Personal representative signature:

Relationship to patient: Date:

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our office. If a claim is submitted to Medicare/Insurance, your health information on this form may be shared with Medicare/Insurance. Your health information which Medicare/Insurance sees will be confidential.

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