



# HERITAGE

*Spinal Care*

Building Health, Hope & Happier Families

## 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? .....	<input type="checkbox"/>	<input type="checkbox"/>
Has your child had any falls down steps? .....	<input type="checkbox"/>	<input type="checkbox"/>
Has your child ever been involved in a motor vehicle accident? .....	<input type="checkbox"/>	<input type="checkbox"/>
Has your child ever been hospitalized or had surgery? .....	<input type="checkbox"/>	<input type="checkbox"/>
Has your child ever had any broken bones or sprain injuries? .....	<input type="checkbox"/>	<input type="checkbox"/>

### 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.**