Child History Form

Please complete this detailed history form and return it to the receptionist. Should you require any assistance, please let us know as we will be happy to assist.

Date : _____________ Child's Name: ________________________________ ( ) M( ) F DOB:________________ Age:_____

Mother: ___________________________ Father: __________________________ Legal Guardian: _______________________

Best Phone: _________________________ ( ) cell ( ) Home **SS NO.:**_______________-___________-______________

Address: ____City:________________________Zip:____________

Email Address: ____@ ________________________.com

☐ Email or ☐ Text me appointment reminders: IF different # or email from above: ________________________________

Who can we thank for referring you? ____

Pediatrician Name:____ Last Appt Date: ____________________

Siblings? Names/ages: ____

I hereby authorize and consent to the chiropractic evaluation and care of my child.

Parent/Guardian Signature: ____

What is your main reason for today's visit? ( ) Wellness Check ( ) Other:

____

List any other care your child has undergone with regard to this complaint including medications:

____

____

Date of onset (mm/yyyy): _________________________ Onset was: ( ) Sudden ( ) Gradual ( ) Associated with an event

Duration of problem/episode: (Check one)
____ ( ) Minutes ( ) Hours ( ) Days ( ) Months ( ) Years

Pattern of Problem: (Check one)
( ) Constant ( ) Intermittent ( ) Occasional ( ) Cyclical

Initiating Factors: ____

Aggravating Factors: ____

Relieving Factors: ____

How does the problem affect your child's body function and daily activities?

____

Prior occurrence or episodes? ____

Other health concerns? ____

Any known allergies? ____

HISTORY OF BIRTH

( ) Hospital ( ) Birthing Center ( ) Home ( ) MD/DO ( ) Midwife

Duration of Pregnancy: ____ Weeks **Birth Weight** ______ **Birth Length** ______ **Hours in labor**: ____________

Was the birth assisted? ( ) Yes ( ) No If yes, how? ( ) Forceps ( ) Vacuum extraction ( ) C-Section ( ) Induced Labor

Were medications given to the mother at birth? ( ) Yes ( ) No If yes, what? ______________________

Was the delivery 'normal'? ( ) Yes ( ) Now If no, what were the complications? ____

Birth Position: ( ) Head first ( ) Breech ( ) Other: ___________ _____ APGAR at Birth ___/10 & after 5 minutes ___/10 □**UKNOWN**

GROWTH AND DEVELOPMENT

Was the infant alert & responsive within 12 hours of delivery? ( ) Yes ( ) No If no, explain__________________________________

Are there any apparent delays? ____

Are there any suspected delays? ____

Sleeps on his/her-*choose all that apply*: ( ) Back ( ) Stomach ( ) Right side ( ) Left Side ( ) Both sides ( ) Incline ( )Unknown

Describe any health problems that exist on the mother &/or fathers side of the family? (i.e. cancer, diabetes etc.)

____

Do the child's siblings have any health problems? ( ) Yes ( ) No If yes, describe: ____

The following information is very important because many of the problems that chiropractors work with are caused by stressors.

CHEMICAL STRESSORS

During pregnancy, did the mother: 1. Smoke ( ) Yes ( ) No 2. Drink alcohol? ( ) Yes ( ) No 3. Drink caffeine? ( ) Yes ( ) no

4. Take Rx/supplements? ( ) Yes ( ) No If yes, what? ___________________ 5. Become ill? If so, how? _________________________

6. Receive ultrasounds? ( ) Yes ( ) No If yes, how many? _____ 7. Receive invasive procedures (i.e. amniocentesis, CVS)? ( ) Yes ( ) No

8. Did Mother exercise during pregnancy? ( )No ( ) Yes 9. Was/IS your child breastfed? ( ) No ( ) Yes, for how long? ______________

At what age was: Formula introduced? _______ Brand? ________ Cows milk?_____yrs/mos Solid foods? _____ yrs/mos

Did your child receive vaccinations? ( ) Yes ( ) No if yes, which ones? __________________ Did your child react to them? ( ) Yes ( ) No

Has your child had antibiotics? ( ) Yes ( ) No If yes, how many & why? ____

Any pets at home? ( ) Yes ( ) No Any smokers at home? ( ) Yes ( ) No Childhood illnesses? ( ) Yes ( ) No ______________________

PSYCHOLOGICAL STRESSORS

Any difficulties with lactation? ( ) Yes ( ) No Any problems bonding? ( ) Yes ( ) No Avg # hours of TV/electronics per week _____hrs

Any behavioral concerns? ( ) Yes ( ) No if yes, explain____

Does your child have difficulties sleeping ( ) Yes ( ) No If yes, explain: ____

TRAUMATIC STRESSORS

Any evidence of trauma during birth? ( ) Bruises ( ) Odd shaped head ( ) Stuck in birth canal ( ) Fast &/or excessively long birth ( ) respiratory depression ( ) cord around neck ( ) other ____

Any falls/accidents during pregnancy? ( ) Yes ( ) No Has the child had any major falls since birth ( ) Yes ( ) No If yes, did the child need stitches or obtain a fracture? Describe: ____

Any hospitalization's? ( ) Yes ( ) No Please explain: ____

Is your child involved in any activities (Yoga; Tumbling, etc)? ( ) Yes ( ) No # Hrs/week? ______ Age child began _____

Signature of Parent or guardian: ____

PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name:____________________ Signature ______________________ Date _______

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patient:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.

Developmental Milestones

Date: ____________ PID: ______________

Name:___________________________________ **DOB:** _________________ **Age:** _____________ **M / F**

GROSS MOTOR SKILLS

- 4 wks Able to hold head up from the table momentarily
- 3 mths Head and shoulder can be supported by forearms
- 4 mths Infant can be pulled up into sit position by the hands
- 6 mths Sits unsupported in the upright position
- 6 mths Head and shoulders can be supported by the arms
- 6 mths Rolls from a face down to a face up position
- 9 mths Crawls
- 9 mths Stands holding onto furniture
- 11 mths Walks with someone holding onto one hand
- 12 mths Walks unassisted
- 2 years Runs
- 2 years Negotiates stairs placing 2 feet on each step
- 3 years Climbs stairs using one foot on each step
- 4 years Walks downstairs with one foot on each step
- 4 years Hops on one foot

SOCIAL SKILLS

- 2 mths Smiles
- 3 mths Reaches for familiar objects
- 4 mths Plays with hands
- 6 mths Plays with feet
- 9 mths Clearly shows joy and pleasure
- 12 mths Feeds self with fingers
- 15 mths Plays peek-a-boo
- 18 mths Understands yes and no

PARENT SIGNATURE:

____

FINE MOTOR SKILLS

- ❑ At birth Primitive grasp reflex present
- ❑ 4 mths Holds & shakes a rattle placed in hand
- ❑ 5 mths Grasps objects independently
- ❑ 6 mths Moves an object from 1 hand to other
- ❑ 6 mths Self-feeding, can hold & eat a cookie
- ❑ 6 mths Checks objects by placing them in Mouth
- ❑ 12 mths Picks up object w/ thumb & index Finger
- ❑ 15 mths Turns 2-3 pages of a book at a time
- ❑ 18 mths Turns pages of a book 1 at a time
- ❑ 24 mths Builds a tower containing at least 5 blocks
- ❑ 4 years Builds a tower containing at least 10 blocks

COMMUNICATION SKILLS

- ❑ 7 wks Makes cooing sounds
- ❑ 3 mths Laughs
- ❑ 5 mths Uses one syllable words, i.e. “da”
- ❑ 8 mths Uses 2 syllable words, i.e. “dada”
- ❑ 12 mths Uses 2 – 3 word vocabulary
- ❑ 24 mths Uses 2 – 3 word phrases

ADAPTIVE SKILLS

- ❑ 10 mths Feeds from a cup unassisted
- ❑ 12 mths Holds own bottle
- ❑ 30 mths Feeds self with utensils
- ❑ 30 mths Able to identify and match some colors
- ❑ 36 mths Copies a circle
- ❑ 42 mths Copies a cross