

WELCOME TO WAYSON FAMILY CHIROPRACTIC, P.C.

Confidential Patient Information

PEDIATRIC HISTORY FORM

Patient Name _____ Date _____

Parents/Guardians _____ Phone# _____

Address _____ City _____ State _____ Zip _____

Birth Date _____ Sex _____ Weight _____ Length/Height _____ SSN _____

Parent/Guardian Email Address _____

Siblings Names & Ages _____

PURPOSE of appointment/symptoms _____

Other doctors seen for this condition: Yes No If yes, list doctor's name & treatments/recommendations received:

Check any of the symptoms your child has suffered from during the past six months:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Ear infections | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> ADHD | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Bed wetting | <input type="checkbox"/> Auto accident | <input type="checkbox"/> Recurring Fevers |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Digestive problems | <input type="checkbox"/> Chronic colds/sore throat | <input type="checkbox"/> Growing pains |
| <input type="checkbox"/> Colic | <input type="checkbox"/> Seizures | <input type="checkbox"/> Temper tantrums | <input type="checkbox"/> Serious Fall |
| <input type="checkbox"/> Other, please explain _____ | | | |

Family History of major illness/disease _____

Previous chiropractor _____ Date of last visit _____ Reason _____

Name of pediatrician _____ Date of last visit _____ Reason _____

Number of doses of antibiotics your child has taken:

1) In past six months _____ 2) Total in his/her life _____

List all other medications, prescription or over-the-counter taken:

1) Currently _____ 2) In past year _____

Vaccination history & ages given _____

Any negative reaction seen to vaccinations? N / Y If yes, describe _____

Childhood diseases:

Chicken Pox: N / Y age: ____ Rubeola: N / Y age: ____ Whooping cough: N / Y age: ____

Rubella: N / Y age: ____ Mumps N / Y Age: ____ Other _____ age: ____

Feeding History:

Breastfed? N / Y If yes, how long? _____ Formula N / Y If yes, how long? _____

Introduced to solids at ____ months. Cow's milk at ____ months Food/Drink Intolerance? _____

Prenatal History:

Name of Obstetrician/Midwife: _____

Complications during pregnancy? N//Y If yes, please list them: _____
 Medications during pregnancy/ Delivery? N / Y If yes, please list them: _____
 Cigarette/Alcohol use during pregnancy? N / Y Any smokers in the home? N / Y
 Location of birth: Hospital ___ Home ___ Other: _____ Complications during delivery? _____
 Birth Interventions: Forceps___ Vacuum Extraction ___ Cesarean Section ___ emergency or planned?
 Genetic Disorder or Disabilities? N / Y If yes, please list: _____
 Birth Weight:_____ Birth Length: _____

Developmental:

During the following times your child's spine is most vulnerable to stress and should be routinely checked by a Doctor of Chiropractic for prevention and early detection of vertebral subluxation & spinal nerve interference.

At what age was your child able to:

Respond to Sound _____ Crawl _____ Respond to visual stimuli _____
 Stand Alone _____ Hold head up _____ Walk Alone _____ Sit up _____

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. bed, changing table, down stairs, stool) **Has your child ever fallen? N / Y**

Do you feel your child's social & emotional development is normal for his/her age? N / Y

Is/Has your child been involved in any high impact or contact sports (i.e. soccer, football, gymnastics, etc)? N / Y

Has your child ever been involved in a car accident or been seen in the Emergency Room? N / Y _____

Other traumas/surgeries not previously mentioned? _____

AUTHORIZATION & RELEASE:

I have answered the above questions to the best of my knowledge and understand that providing inaccurate information is dangerous to my child's health. I hereby authorize Wayson Family Chiropractic to administer care to my son/daughter.

I also authorize payment of insurance benefits directly to Dr. Blake Wayson or Wayson Family Chiropractic, P.C. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I clearly understand and agree that I am personally responsible for payment of all services, which are rendered to me that my insurance company does not pay. I also understand that if I suspend or terminate my care and my treatment, any fees for professional services, which are rendered to me, will be immediately due and payable. Should my account become delinquent, I will be responsible for any interest (to accrue at the rate of 18% annually, commencing 30 days after the initial bill for services is issued), for collection fees, including but not necessarily limited to attorneys fees and court costs incurred in collection attempts on my account. I hereby authorize Wayson Family Chiropractic to release any information to my insurance company/attorney acquired in the course of my examination or care. I understand that a photocopy of the above assignment and authorization will be deemed as valid as the original. I authorize for Wayson Family Chiropractic to contact me at my listed phone numbers and leave pertinent phone messages related to myself & appointments.

SIGNED _____ RELATIONSHIP TO PT _____ DATE _____

Our goal is to bring better health to our community. The best way for us to reach others is through word of mouth & satisfied patient referrals. The greatest compliment a patient can give is a referral of friends and family.

How did YOU find our office or whom may we thank for your referral? _____