CALHOUN CHIROPRACTIC
Wellness Center

NEW PRACTICE MEMBER PAPERWORK

PEDIATRIC PRE-EXAM FORM

3 MONTHS – 2 YEARS

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phone 585.924.9540 | **fax** 585.924.4615
website http://calhounchiropractic.net/

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PEDIATRIC PRE-EXAM FORM (3 months to 2 years)

Appointment Date: _____

Please fill out all information as thoroughly as you can. Thank you.

PERSONAL INFORMATION

Child's First Name: _____ M.I.: _____ Last Name: _____

Birth Date: _____ Age: _____ Sex: M F

Address: _____ City/State/Zip: _____

Mother's Name: _____ Father's Name: _____

Mother's Phone: ( ) _____ Father's Phone: ( )_____

Parent's Marital Status: Married ____ Single ____ Divorced ____ Widowed ____

Number of Siblings: _____ Sibling(s) Names & Ages: _____

_____

Predominant language used in home: _____

Who can we thank for referring you to our office? _____

REASON FOR SEEKING CARE

What is your reason for seeking care at Calhoun Chiropractic Wellness Center? _____

_____

When did this begin? (If applicable) _____

What is affecting your child's life most? _____

_____

Are there any major injuries and/or surgeries we should know about? _____

_____

Has your child seen any other providers for this condition? (list all conditions and the doctor seen):_____

_____

Has your child seen a chiropractor before? ***Yes*** ***No*** If yes, How long ago? _____

Clinic/Doctor Name: _____ What is your reason for the change? _____

_____

What health goal would have the greatest impact on his/her life? _____

CONSENT TO TREAT

Who is/are the legal guardian(s) of this child? _____

Being the parent or legal guardian of this child, I hereby authorize this office and its doctors to examine, x-ray (if necessary), and administer care to my son/daughter named _____ as the examining/treating doctor deems necessary. I understand and agree that I am personally responsible for payment of all fees charged by this office for such care.

Parent/Guardian's signature: _____ Date: _____

Witnessed by: _____

PREGNANCY HISTORY

Location of birth: ○Home ○Birthing Center ○Hospital ○Other: _____

The duration of pregnancy in weeks: _____ Birth weight: _____ Birth length: _____Apgar Score: _____

Did any of the following happen during delivery: ○C-section ○Doctor pulled or twisted baby ○Anesthesia ○Labor was induced ○Forceps/vacuum extraction ○Premature delivery ○Special medical procedures/tests

Describe any of the above plus any additional complications experienced during delivery: _____

_____

What was the baby's position during pregnancy/birth? ○Anterior ○Posterior ○Breach ○Transverse ○Other_____

Did any of the following happen during pregnancy: ○Falls ○Motor Vehicle Accident ○High blood pressure ○Anemia ○Gestational Diabetes ○Morning Sickness ○Indigestion ○Seizures ○Swollen ankles ○Thyroid problems ○Heart problems ○Back pain ○Abnormal bleeding ○Any other illnesses _____

Were any of these used during pregnancy: ○Tobacco ○Alcohol ○non-prescribed drugs ○Prescription Medications ○Over-the-counter meds ○Other: _____

Please list any medications you or your baby is taking: _____

_____

Did your child receive any of the following nutrition: ○Breast milk ○Commercial formula ○Cow's milk ○Goat's milk ○Other milk ○ Vitamins ○ Medication ○ Juice: Vegetable ○ Juice: Fruit ○ Other: _____

Check if you have introduced the following into the child's diet (and at how many weeks):

○Sweets _____○Solid foods_____ ○ Other_____

HEALTH HISTORY 3MONTHS TO 2 YEARS

Nutrition

Is your child being breast fed? ○Yes ○No ○Never breast fed *If no, for how long was he/she breast fed?* _____

If breast feeding, how much cow's milk does the mother consume daily? _____ How much cow's milk does the child consume daily? _____ Is your child formula fed? ○Yes ○No *If yes, which formula or other milk source?* _____

Does your child have any feeding difficulties? ○Yes ○No Does your child have any digestive difficulties? ○Yes ○No

Do you have any concerns about your child's diet? ○Yes ○No *What?* _____

Does your child have any food allergies? ○Yes ○No List *all allergies:* _____

Does your child have any persistent or intermittent skin rashes? ○Yes ○No *If yes, where?* _____

Does your child take any vitamin supplements? ○Yes ○No _____

Does your child eliminate stools each day? ○Yes ○No *How often?* _____

What foods does your child eat for: 1) Breakfast? _____ 2) Lunch? _____

_____3) Dinner? _____4) Snacks? _____

_____ 5) What are your child's favorite foods? _____

6) What type of fast foods or fried foods does your child like to eat? _____

Trauma

Has your child had any recent falls, sprains, strains, or physical, chemical, or emotional trauma? ○Yes ○No

If yes, describe the trauma and date it occurred: _____

Has your child ever fallen from a bicycle, skateboard, scooter, rollerblades or similar? ○Yes ○No _____

Has your child ever fallen down stairs or fallen from a significant height? ○Yes ○No _____

Has your child ever been in a car accident or near miss? ○Yes ○No _____

Has your child ever had a bone fracture or joint dislocation? ○Yes ○No _____

Has your child had any other injuries? ○Yes ○No _____

Does your child ever bang his/her head repeatedly against a wall, bed or other object? ○Yes ○No _____

CONT. HISTORY

Growth and Development

Can your child sit unsupported? ○Yes ○No *If yes, what age did your child start to sit up?* _____*months*

Is your child crawling? ○Yes ○No *If yes, at what age did your child start crawling?* _____ *months*

Is your child walking? ○Yes ○No *If yes, at what age did your child start walking?* _____ *months*

Does your child often trip or fall? ○Yes ○No *How often?* _____

3 MONTHS TO 2 YEARS HEALTH HISTORY CONT.

Health History

Has your child had colic? ○Yes ○No *If yes, when and for how long?* _____

Has your child had any upper respiratory infections? ○Yes ○No *How often?* _____

Has your child had asthma? ○Yes ○No *If yes, what induces it?* _____

Does your child complain of back or neck pain? ○Yes ○No *How often?* _____

Does your child complain of pains in the arms or legs? ○Yes ○No *How often?* _____

Does your child complain of headaches? ○Yes ○No *How often?* _____

Has your child had any earaches? ○Yes ○No *If yes, at what age did the first earache occur?* _____

How frequently does your child have earaches? _____

Do the earaches usually tend to occur in the same ear? ○Yes ○No ○Right ○ Left ○ Both

Has your child had any other illnesses? ○Yes ○No *Please list each illness and its approximate date:* _____

_____

Is your child presently receiving any medications? ○Yes ○No Please list: _____

Has your child ever been to a hospital or emergency room for evaluation or treatment? ○Yes ○No

Has your child recently been vaccinated? ○Yes ○No What *vaccinations?* _____

Do you have any other concerns about your child's health? ○Yes ○No If *yes, what concerns?* _____

Is your child allergic to anything? ○Yes ○No *If yes, what?* _____

_____

FAMILY MEDICAL HISTORY

Please check if any of your blood relatives have/had any of the following illnesses and mark accordingly by noting: M (mother), F (father), S (sibling), PGM (paternal grandma), MGM (maternal grandma), PGF (paternal grandfather), MGF (maternal grandfather):

_____Allergy ○Have ○Had _____Asthma ○Have ○Had _____Eczema ○Have ○Had

_____Cancer○ Have ○Had _____Low Blood Sugar ○Have ○Had _____Heart Trouble ○Have ○Had

_____High Blood Pressure○ Have ○Had _____Stroke○ Have ○Had _____Kidney disease ○Have ○Had

_____Liver Disease ○Have ○Had _____ Mental Retardation ○Have ○Had _____Autism ○Have ○Had

_____Mental Illness ○Have ○Had _____Scoliosis ○Have ○Had _____ Ulcer ○Have ○Had

_____Diabetes ○Have ○Had

Please list all blood relatives who are deceased, the cause of death, and their age of death:

_____

_____

OTHER

Any other information or concerns about your child's health?

_____

_____

_____

_____

Acknowledgments

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials _____ **I am the legal guardian of the child noted here.**

Initials _____ **I give permission to the providers of Calhoun Chiropractic Wellness Center to provide care for my child noted in lieu of my absence.**

Initials _____ **I instruct Dr. Justin P. Calhoun, D.C. and Dr. Luke J. Sparaccio, D.C. to deliver the care that, in his or her professional judgment, can best help my child in the restoration of his/her health. I understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing from medicine and does not proclaim to cure any named disease or entity.**

Initials _____ **I may request a copy of the Privacy Policy and understand it describes how my child's health information is protected and released on my behalf for seeking reimbursement from any involved third parties.**

Initials _____ **I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my child's care in this office.**

Initials _____ **I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services my child receives.**

Initials _____ **To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my child's concern.**

Initials _____ **I understand that the doctor(s) at Calhoun Chiropractic Wellness Center are Doctors of Chiropractic (D.C.) and will be providing my child with chiropractic treatment. I fully understand that there is no guarantee that such treatment/care will improve his/her condition. Many practice members have over the years been treated by chiropractors for various conditions, some of which respond to treatment, and others which may not, despite the best of care. I understand that it is my responsibility to keep an open line of communication with my doctor as to how he/she is progressing. Chiropractic treatment by nature often involves frequent office appointments in order to maximize the benefits of the care.**

Print Practice Member Name: _____

Relationship to Practice Member: _____

Parent/Guardian Signature: _____ **Date: _____**

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Patient Birth Records Release

I, _____, parent (or legal guardian) of the below mentioned child, hereby authorize and direct _____ (pediatrician's name) to release the records relating to the birth of _____, to Calhoun Chiropractic Wellness Center noted above. May this signed consent form be your good authority to do so.

Your Date of Birth (MM/DD/YYYY):_____/_____/_____
Your Child's Date of Birth (MM/DD/YYYY): _____/_____/_____

Your Name: _____ Date: _____

Your Signature: _____

Witness: _____ Date: _____

Thank you! We are grateful you have chosen to bring your child to Calhoun Chiropractic Wellness Center, and look forward to being a part of your family's wellness journey.