BODYWISE CHIROPRACTIC PLLC

PLEASE TELL US ABOUT YOUR CHILD!

TODAY'S DATE ____/___/ ____

NAME _____ MALE __ FEMALE __ MOTHER_____ FATHER_____

BIRTHDATE _____/_____/_____ AGE_____BIRTH WEIGHT _____ BIRTH LENGTH_____ CURRENT WEIGHT_____

MOM/DAD EMAIL ADDRESS _____

STREET ADDRESS _____ HOME PHONE _____-_____-_____

CITY _____ STATE _____ ZIP CODE _____ MOM/DAD CELL PHONE _____-_____-_____

REFERRED TO OUR OFFICE BY _____

THIRD TRIMESTER PRESENTATION: VERTEX_____ BREECH_____TRANSVERSE_____FACE/BROW_____

TYPE OF BIRTH: NORMAL VAGINAL_____ FORCEPS_____ CESAREAN____ SUCTION CAP/VACUUM____

PLACE OF BIRTH: HOME___ BIRTHING CENTER___ HOSPITAL____

PROBLEMS DURING PREGNANCY_____

PROBLEMS DURING LABOR/DELIVERY_____

APGAR SCORES_____ _____ WAS THERE PRESENCE AT BIRTH OF: JAUNDICE (YELLOW)?_____ CYANOSIS (BLUE)?_____

CONGENITAL ANOMALIES/DEFECTS?_____ IF YES, PLEASE EXPLAIN_____

INFANT FEEDING: BREAST_____ BOTTLE_____ IF BOTTLE, WHICH FORMULA?_____

NUMBER OF HOURS SLEEPING PER NIGHT_____ QUALITY OF SLEEP: GOOD____ FAIR___ POOR___

OBSTETRICIAN/MIDWIFE_____

PEDIATRICIAN/FAMILY MD_____

DATE OF LAST VISIT_____ PURPOSE_____

IMMUNIZATION HISTORY_____

NUMBER OF DOSES OF ANTIBIOTICS CHILD HAS TAKEN: LAST 6 MONTHS_____ DURING LIFETIME_____

PURPOSE OF THIS APPOINTMENT_____

INSURANCE/BILLING INFORMATION_____ POLICY #_____

AUTHORIZATION FOR CARE OF MINOR

I HEREBY AUTHORIZE THIS OFFICE AND ITS DOCTOR TO ADMINISTER CARE AS THEY SO DEEM NECESSARY TO MY SON/DAUGHTER.

SIGNED_____ WITNESSED_____ DATE_____

PEDIATRIC CASE HISTORY

DELIVERY/BIRTH HISTORY _____

_____

_____

AT WHAT AGE DID THE CHILD:

RESPOND TO SOUND_____ FOLLOW AN OBJECT WITH FACE/EYES_____ HOLD HEAD UP_____

SIT ALONE_____ CRAWL_____ STAND_____ WALK ALONE_____

AT WHAT AGE, IF EVER, DID THIS CHILD SUFFER FROM THE FOLLOWING CHILDHOOD DISEASES?

CHICKENPOX_____ MUMPS_____ MEASLES_____ RUBELLA_____ RUBEOLA_____ WHOOPING COUGH_____ OTHER_____

HAS THIS CHILD EVER SUFFERED FROM (PLEASE CIRCLE/FILL IN BLANK):

HEADACHES	ORTHOPEDIC PROBLEMS	DIGESTIVE PROBLEMS	BEHAVIORAL PROBLEMS
DIZZINESS	NECK PROBLEMS	POOR APPETITE	ADD/ADHD
FAINTING	ARM PROBLEMS	STOMACH ACHES	RUPTURES/HERNIA
SEIZURES/CONVULSIONS	LEG PROBLEMS	REFLUX	MUSCLE PAIN
HEART TROUBLE	JOINT PROBLEMS	CONSTIPATION	GROWING PAINS
CHRONIC EARACHES	BACKACHES	DIARRHEA	ALLERGIES TO_____
SINUS TROUBLE	POOR POSTURE	DIABETES	ALLERGIES TO_____
ASTHMA	SCOLIOSIS	HYPERTENSION	ALLERGIES TO_____
COLDS/FLU	WALKING TROUBLE	ANEMIA	OTHER_____
COLIC	BROKEN BONES	BED WETTING	OTHER_____

WE INVITE YOU TO DISCUSS FRANKLY WITH US ANY QUESTIONS REGARDING OUR SERVICES. THE BEST CHIROPRACTIC CARE IS BASED ON A FRIENDLY, MUTUAL UNDERSTANDING BETWEEN DOCTOR AND PATIENT.

OUR OFFICE POLICY REQUIRES PAYMENT IN FULL FOR ALL CHIROPRACTIC SERVICES RENDERED AT THE TIME OF VISIT, UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE WITH OUR BUSINESS OFFICE.

I HEREBY AUTHORIZE PAYMENT OF BENEFITS DIRECTLY TO DOCTOR OF BENEFITS DUE ME FOR SERVICES RENDERED. I FURTHER AUTHORIZE DOCTOR TO RELEASE ANY INFORMATION REQUIRED TO PROCESS INSURANCE CLAIMS.

I UNDERSTAND THE ABOVE INFORMATION AND GUARRANTEE THIS FORM WAS COMPLETED TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES IN MY HEALTH STATUS.

SIGNATURE OF PATIENT'S PARENT/GUARDIAN (RESPONSIBLE PERSON) _____ **DATE** ____/_____/_____