APPLICATION FOR CARE AT CITY OF PALMS CHIROPRACTIC

11621 South Cleveland Avenue, Fort Myers, FL 33907
239.690.7794

PEDIATRIC HISTORY FORM

PATIENT DEMOGRAPHICS HR#: _____

Childs Name: _____ Today's Date: _____/_____/____

Date of Birth: _____/_____/_____ Birth Height: _____ Birth Weight: _____ Current Height: _____

Current Weight: _____ Age: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Mothers Name: _____ Mother's Mobile: _____ DOB: ____/____/____

Fathers name: _____ Father's Mobile: _____ DOB: ____/____/____

Email: _____ ☐ I agree to receive emails and texts from City of Palms Chiropractic

Pediatrician/Family MD: _____ City & State: _____

Last Visit: ____/____/____ Reason for visit: _____

Who is responsible for this bill? _____

☐ Father's Social Security # _____-_____-_____ ☐ Mother's Social Security # _____-_____-_____

☐ Other *(please explain):*

CHILD'S CURRENT PROBLEM:

Purpose of this visit: _____ Wellness Check-up _____ Injury or Accident _____ Other

Please explain: _____

*If your child is experiencing **Pain/Discomfort, please identify where and for how long:***

_____

_____

1. **When did the** Problem first begin? Date: ____/____/_____ _____ Unknown _____ Gradual _____ Sudden
2. **Ever had** this problem **before**? ❑ Yes ❑ No **If yes,** when? _____
3. Any **bowel or bladder** problems since this problem began? **If yes**, *(Describe)*: _____

_____

4. Have you seen any **other doctors** for this problem? ❑ Yes ❑ No **If yes,** who? _____

5. How long ago? _____ Days _____ Weeks _____ Months _____ Years

6. What were the results of past treatment?

   _____

7. How is this problem **NOW?:**

   ☐ Rapidly Improving ☐ Improving Slowly ☐ About the Same ☐ Gradually Worsening ☐ On & Off

8. Please list any **medication taken** for this problem:

   _____

9. Has your child ever sustained an injury playing organized sports? _____ **If yes**, please explain: _____

   _____

10. Has your child ever sustained an injury in an auto accident? _____ **If yes**, please explain: _____

    _____

Health History:

Has your child ever taken antibiotics? ☐ Yes ☐ No Condition Treated: _____

Has your child ever been involved in a car accident? ☐ Yes ☐ No Date & Injuries: _____

Has your child ever fallen head first from (Changing Table, Bed, Stairs…) ☐ Yes ☐ No _____

Other traumas not described above? ☐ Yes ☐ No Type & Date: _____

Prior surgery: ☐ Yes ☐ No Type and Date: _____

Prenatal History:

Location of Birth: ☐ Home ☐ Birthing Center ☐ Hospital ☐ Stepchild ☐ Adopted

Complications during pregnancy: ☐ Yes ☐ No List: _____

Ultrasounds during pregnancy: ☐ Yes ☐ No Number: _____

Medications during pregnancy/delivery: ☐ Yes ☐ No List: _____

Cigarette / Alcohol use during pregnancy: ☐ Yes ☐ No

Birth intervention: ☐ Forceps ☐ Vacuum ☐ Caesarian, Why?_____

Complications during delivery: ☐ Yes ☐ No List: _____

Genetic disorders or disabilities: ☐ Yes ☐ No List: _____

APGAR scores: 1 min _____ 5 min _____

Feeding History:

Breast Fed: ☐ Yes ☐ No How long?_____ Formula fed: ☐ Yes ☐ No How long?_____

Formula Type:_____ Introduced to solids at: _____ months. Introduced cow's milk at: _____ months

Food / juice allergies or intolerances ☐ Yes ☐ No List: _____

Developmental History:

Sleep (Hours per night): _____ Naps (number & lengths): _____ Problems sleeping: _____

At what age was your child able to: Crawl ____ Sit alone ____ Stand-alone ____ Walk alone ____ Say words ____

Childhood Diseases:

☐ Chicken Pox - Age ___ ☐ Mumps - Age ___ ☐ Rubella - Age ___ ☐ Whooping cough - Age ___

☐ Measles - Age ___ ☐ Meningitis - Age ___ ☐ Tuberculosis - Age ___ ☐ Other: _____Age ___

Vaccination History:

☐ HBV / Hep B (Hepatitis B) – Age ___

☐ DTP or DTaP (Diphtheria, Tetanus, Pertussis) – Age ___

☐ HbCV / Hib (H. influenzae type b conjugate) – Age ___

☐ OPV (Oral Polio Vaccine) – Age ___

☐ MMR (Measles, Mumps, Rubella) – Age ___

☐ Varicella (Chicken Pox) – Age ___

☐ PCV (Pneumoccocal) – Age ___

☐ IPV (Inactivated Poliovirus) – Age ___

Adverse Reactions to Any Vaccine? ☐ Yes ☐ No List: _____

HAS YOUR CHILD EVER SUFFERED FROM: *mark a **Y** for YES OR **N** for NO*

☐ Headaches	☐ Orthopedic Problems	☐ Digestive Disorders	☐ Behavioral Problems
☐ Dizziness	☐ Neck Problems	☐ Poor Appetite	☐ 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	☐ Sinus Trouble	☐ Poor Posture
☐ Hypertension	☐ Asthma	☐ Scoliosis	☐ Anemia
☐ Colds/Flu	☐ Walking Trouble	☐ Bed Wetting	☐ Colic
☐ Broken Bones	☐ Sleeping Problems	☐ Fall in baby walker	☐ Fall from bed or couch
☐ Fall from crib	☐ Fall off swing	☐ Fall off bicycle	☐ Fall from high chair
☐ Fall off slide	☐ Fall down stairs	☐ Fall from changing table	☐ Fall off monkey bars
☐ Fall off skateboard/skates		☐ ADD/ADHD	

☐ Allergies to: _____

☐ Other: _____

I understand that I am directly and fully responsible to City of Palms Chiropractic for all fees associated with chiropractic care my child receives.

☐ The risks associated with exposure to x-rays and spinal adjustments have been explained to me to my complete satisfaction, and I have conveyed my understanding of these risks to the doctor. After careful consideration, I do hereby request and authorize imaging studies and chiropractic adjustments for the benefit of my minor child for whom I have the legal right to select and authorize health care services on behalf of.

☐ Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other guardian is not required. If my authority to so select and authorize this care should change in any way, I will immediately notify this office.

☐ **NO-SHOWS and CANCELATIONS** – We understand that life and emergencies happen, but we do ask that if you cannot keep your appointment, please call us within 24 hours to cancel and reschedule your appointment. You can leave a message on our answering machine or send us an email and one of our staff members will gladly reschedule your appointment for you. **If you do not show up for your appointment, and did not call within 24 hours in advance, you will be charged a $35 NO-SHOW FEE for existing patients and a $50 NO-SHOW FEE for new patients. *First offense* – No charge, graceful warning. *Second (+) offenses* - $35 NO-SHOW FEE.**

CONSENT TO CHIROPRACTIC CARE

I certify that the information that I have supplied is correct and accurate to the best of my knowledge.

I, _____, being the parent or legal guardian of _____ hereby grant permission for my child to receive chiropractic care.

_____ _____

Parent or Legal Guardian's Signature Date

_____ _____

Doctor's Signature Date