*Whom may we thank for referring you to our office?*_____

Thrive Chiropractic and Wellness
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Pediatric History Form

(10 years of age and under)

Today's Date _____/_____/_____

Name _____ Date of Birth _____/_____/_____ Social Security # _____-_____-_____

Address _____ City _____ State _____ Zip _____

Phone (H) _____ Mothers mobile: _____ Fathers mobile: _____

Mother _____ DOB _____/_____/_____ Father _____ DOB _____/_____/_____

Pediatrician/Family MD _____ City & State _____ Last Visit: _____/_____/_____

Purpose of last visit: _____

Birth Height: _____ Birth Weight: _____ Current Height: _____ Current Weight: _____ Age: _____

Ever been under chiropractic care? ☐ No ☐ Yes: Who/When? _____

Who is responsible for this bill? ☐ Mother ☐ Father ☐ Other (please explain) _____
Insurance Company _____

PREGNANCY HISTORY:

Third Trimester Presentation: ☐ Vertex ☐ Breech ☐ Transverse ☐ Face/Brow

Type of Birth: ☐ Normal Vaginal ☐ Forceps ☐ Cesarean ☐ Suction Cap or Vacuum

Location: ☐ Home ☐ Hospital ☐ Birthing Center ☐ Other: _____

Problems during Pregnancy: _____

Problems during Labor/Delivery: _____

Was there presence of: ☐ Jaundice? (yellow) ☐ Cyanocic? (blue) ☐ Congenital Anomalies/Defects?

If yes, please explain _____

INFANT HISTORY:

Infant feeding: ☐ Breast ☐ Bottle If Bottle; which formula? _____

Number of Hours sleep per night _____ Quality of Sleep: ☐ Good ☐ Fair ☐ Poor

List date of most recent **IMMUNIZATIONS** your child has had: _____

Did they have a negative reaction: ☐ Yes ☐ No If yes please explain:_____

☐ I do NOT immunize my child(ren) ☐ I would like more information on Philosophical or Religious Exemptions that allow me NOT to immunize my child.

Has your child ever been treated at the emergency room? ☐ Yes ☐ No If yes; please explain: _____

Has your child ever been hospitalized? ☐ Yes ☐ No If yes; please explain: _____

Has your child ever had any surgeries? ☐ Yes ☐ No If yes; please explain: _____

Is your child currently on any medications? ☐ Yes ☐ No If yes; please list: _____

AT WHAT AGE DID THE CHILD:

Respond to sound _____ Follow an object with his/her eyes _____ Hold head up _____

Sit Alone _____ Crawl _____ Stand _____ Walk Alone _____

AT WHAT AGE, IF EVER, DID CHILD SUFFER FROM THE FOLLOWING:

Chicken pox _____ Mumps _____ Measles _____ Rubella _____ Whooping Cough _____

Other: _____

HAS YOUR CHILD EVER SUFFERED FROM:

☐ Headaches	☐ Orthopedic Problems	☐ Digestive Disorders	☐ 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	☐ Hypertension	☐ Allergies to _____
☐ Asthma	☐ Scoliosis	☐ Anemia	☐ Allergies to _____
☐ Colds/Flu	☐ Walking Trouble	☐ Bed Wetting	☐ Other: _____
☐ Colic	☐ Broken Bones	☐ Sleeping Problems	☐ Other: _____

HAS YOUR CHILD EVER SUFFERED THE FOLLOWING SPINAL TRAUMAS:

☐ Fall in baby walker	☐ Fall from bed or couch	☐ Fall off skateboard or skates	☐ 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	☐ Other: _____

Has your child ever sustained an injury playing organized sports? ☐ Yes ☐ No If yes; please explain: _____

_____

Has your child ever sustained an injury in an auto accident? ☐ Yes ☐ No If yes; please explain: _____

_____

FAMILY HISTORY:

Please indicate if your child or a family member has had any of the following: *Write "C" for child, "F" for family member:*

_____ Heart Disease _____ Diabetes _____ Stroke _____ Cancer _____ High/Low Blood Pressure

_____Asthma _____ Gastrointestinal disease _____ Memory/mood disorder _____ Thyroid problem

CHILD'S CURRENT PROBLEM:

Purpose of this visit: ☐ Wellness ☐ Check-up ☐ Other: _____

☐ Pain/Discomfort; explain _____

☐ Injury; explain _____

If due to Pain/Discomfort/Injury, please fill out:

1. **Onset** of Problem: Date ____/____/____ ☐ Unknown ☐ Gradual ☐ Sudden
2. **Ever had** this problem **before**? ☐ No ☐ Yes If yes; when? _____
3. Any **bowel or bladder** problems since this problem began? ☐ No ☐ Yes If yes; when? _____
4. Any **medication taken** for this problem? ☐ No ☐ Yes If yes; when? _____
5. Have you seen any **other doctors** for this problem? ☐ No ☐ Yes If yes; when? _____
6. How is this problem **NOW:** ☐ Rapidly Improving ☐ Improving Slowly ☐ About the same ☐ Gradually Worsening ☐ On and Off

General Consent Form: The information within this chart is confidential. I understand that all requests for release of my records must be in writing. Protected health information will be released with written authorization, with minimum disclosure necessary as related to your care. Please see Notice of Privacy Practices for more detailed information. I understand that I have a responsibility to communicated honestly with Dr. Powell or Dr. Gentilini, and to notify him/her of any changes in health status.

Financial Awareness and Consent: I understand I am financially responsible, WHETHER OR NOT MY INSURANCE COMPANY PAYS, for all charges incurred. I hereby assign my major medical insurance benefits, including Medicare, private insurance, and other health plans to Thrive Chiropractic and Wellness. Any overpayment will promptly be refunded. I also authorize Thrive Chiropractic and Wellness to release any protected health information required to secure payment.

HIPAA Privacy Practices: I understand that a copy of my HIPAA rights is available to me upon request.

Responsible Party's Signature: _____ **Date** _____/_____/_____