

PEDIATRIC HISTORY FORM

Dear **New Patient**,

It is a pleasure to welcome you to King of Prussia Family Wellness Center. Please let us know if there is any way we can make you and your family feel more comfortable. To help us serve you better, please complete the following information. We look forward to working with you to build better health for your family.

Patient Name: _____ Birth Date: _____

Address: _____ City: _____

State: _____ Zip: _____ Email for reminders: _____

Home phone: _____ Cell Phone: _____ Other Phone: _____

Sex: _____ Weight: _____ Height: _____ Referred By: _____

Names of Parents / Guardians: _____

Purpose of Evaluation _____

Other Doctors Seen for this Condition: _____ N _____ Y , Doctors' Names and Prior Treatments: _____

Other Health Problems? _____

Check any of the Following Conditions Your Child has suffered from During the Past Six Months:

Ear Infections	Scoliosis	Seizures	Chronic Colds	Headaches
Asthma / Allergies	Digestive Problems	ADHD	Recurring Fevers	Growing / Back Pains
Colic	Bed Wetting	Car Accident	Temper Tantrums	Other _____

Family History: _____

Previous Chiropractor: _____

Date of Last Visit: _____ / _____ / _____ Reason: _____

Name of Pediatrician: _____

Date of Last Visit: _____ / _____ / _____ Reason: _____

Are You Satisfied with the Care Your Child has Received There ? _____ N _____ Y

Number of Doses of Antibiotics Your Child has Taken:

During the Past Six Months: _____, Total During His / Her Lifetime: _____

Number of Doses of Other Prescription Medications Your Child has Taken:

During the Past Six Months: _____, Total During His / Her Lifetime: _____ List: _____

Vaccination History: _____

Prenatal History:

Name of Obstetrician / Midwife: _____

Complications During Pregnancy ? _____ N _____ Y , List: _____

Ultrasounds During Pregnancy ? _____ N _____ Y, Number: _____

Medications During Pregnancy / Delivery ? _____ N _____ Y , List: _____

Cigarette / Alcohol Use During Pregnancy: _____ N _____ Y

Location of Birth: _____ Hospital _____ Birthing Center _____ Home

Birth Intervention: _____ Forceps _____ Vacuum Extraction
_____ Caesarian Section, Emergency or Planned?

Complications During Delivery ? _____ N _____ Y, List: _____

Genetic Disorders or Disabilities: _____ N _____ Y, List: _____

Birth Weight: _____ Birth Length: _____ APGAR Scores: _____

Feeding History:

Breast Fed: _____ N _____ Y, How Long: _____

Formula Fed: _____ N _____ Y, How Long: _____ Type: _____

Introduced to Solids at: _____ Months, Cows' Milk at _____ Months

Food / Juice Allergies or Intolerances: _____ N _____ Y, List: _____

Developmental History:

During the following times your child's spine is most vulnerable to stress and should routinely be 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

_____ Cross 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., a bed, changing table, down stairs, etc.). Was this the case with your child? _____ N _____ Y

Is / has your child been involved in any high impact or contact type sports (i.e., Soccer, Football, Gymnastics, Baseball, Cheerleading, Martial Arts, etc.) ? _____ N _____ Y, List: _____

Has Your Child Ever Been Involved in a Car Accident? _____ N _____ Y, List: _____

Has Your Child Been Seen on an Emergency Basis? _____ N _____ Y, List: _____

Other Traumas Not Described Above? _____ N _____ Y, List: _____

Prior Surgery: _____ N _____ Y, List: _____

Menarche: _____ N _____ Y, Age: _____

Childhood Diseases:

Chicken Pox N / Y, Age _____

Mumps N / Y, Age _____

Rubella N / Y, Age _____

Whooping Cough N / Y, Age _____

Measles N / Y, Age _____

Other N / Y, Age _____

**WE ARE HERE TO SERVE YOU, AND ENCOURAGE YOU TO ASK QUESTIONS.
YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR RESULTS.**

FINANCIAL POLICIES

We are committed to great service... and expect to be fairly paid for it.

It is our firm office policy that all services rendered in this office are charged directly to you, the client. You are personally and fully responsible for all payments regardless of whether or not we accept insurance assignment. Please realize that insurance companies do not guarantee payment. Each case is subject to review and individualized rulings.

By signing below, you agree to keep your balance (co-pay or otherwise) at \$150 or less, unless other arrangements were made prior to treatment.

If you are an insurance assignment patient, you agree to first meet your deductible in full and pay your co-insurance at the time service is rendered or at the end of each week.

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account.

Returned checks and balances over 30 days may be subject to additional collection fees and interest charge of 1.5% per month.

WE WILL FILE YOUR INSURANCE FOR YOU:

I understand and agree that health and accident policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to King of Prussia Family Wellness Center will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

- I understand that only structural diagnoses may be covered by insurance and have had the opportunity to ask questions regarding this. **Insurance will not pay for organic problems outside the spine such as: ear infections, immunity, colic, irritability, constipation, failure to thrive, and wellness visits. Please initial if you acknowledge that you will be charged cash prices and that these services will not be going through your insurance and cannot be billed.** _____
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

Thank you for your cooperation. We will always give you 100%, and we thank you for doing the same.

By signing, I understand and agree to comply with each of the Financial Policies outlines above.

Signature _____ Date _____

RELEASE OF MEDICAL INFORMATION

I hereby authorize the release of any medical information necessary to process any insurance claim.

Signature _____ Date _____

TREATMENT OF A MINOR

I as legal guardian of patient do authorize appropriate chiropractic treatment.

Signature _____ Date _____

Relationship to Patient _____