



### Pediatric Form

Name \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age \_\_\_\_ Male/Female

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Guardian(s) Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_

Who may we thank for referring you? \_\_\_\_\_



### List The Health Concerns That Brought You Into This Office



Health Concern: List according to severity. ↓	Rate of Severity 0 = no pain 10 = unbearable	When did this problem start?	Have you had the problem before? If so, when?	Did the problem begin with an injury?	Are symptoms constant (C) or intermittent (I)?
Primary: _____	_____	_____	_____	_____	_____
Second: _____	_____	_____	_____	_____	_____
Third: _____	_____	_____	_____	_____	_____
Fourth: _____	_____	_____	_____	_____	_____

Have you ever seen other doctors for these conditions?  Yes  No

If Yes:  Chiropractor  Medical doctor  Other \_\_\_\_\_

Who? \_\_\_\_\_ When? \_\_\_\_\_ Results? \_\_\_\_\_

### Please Mark "P" For In The Past OR Mark "C" For Currently Have:

- |  |   |   |   |  |
|--|---|---|---|--|
| <input type="checkbox"/> Headaches       | <input type="checkbox"/> Ear Infections       | <input type="checkbox"/> Sinus Issues     | <input type="checkbox"/> Kidney Problems      | <input type="checkbox"/> Migraines                   |
| <input type="checkbox"/> Hearing Loss    | <input type="checkbox"/> Frequent Colds       | <input type="checkbox"/> Bladder Problems | <input type="checkbox"/> Sleep Problems       | <input type="checkbox"/> Diabetes                    |
| <input type="checkbox"/> Jaw/TMJ Pain    | <input type="checkbox"/> Ringing in the Ears  | <input type="checkbox"/> Thyroid Issues   | <input type="checkbox"/> Seizures             | <input type="checkbox"/> Tight/Sore Muscles          |
| <input type="checkbox"/> Neck Pain       | <input type="checkbox"/> Dizziness            | <input type="checkbox"/> Asthma           | <input type="checkbox"/> Scoliosis            | <input type="checkbox"/> Sports Injury               |
| <input type="checkbox"/> Shoulder Pain   | <input type="checkbox"/> Loss of Energy       | <input type="checkbox"/> Chest Pain       | <input type="checkbox"/> Infertility          | <input type="checkbox"/> Sciatica                    |
| <input type="checkbox"/> Arm Pain        | <input type="checkbox"/> Nervousness          | <input type="checkbox"/> Heart Problems   | <input type="checkbox"/> Fibromyalgia         | <input type="checkbox"/> Joint Pain                  |
| <input type="checkbox"/> Upper Back Pain | <input type="checkbox"/> Double/Blurry Vision | <input type="checkbox"/> Nausea           | <input type="checkbox"/> Epilepsy/Convulsions | <input type="checkbox"/> GERD/Gastric Reflux         |
| <input type="checkbox"/> Mid Back Pain   | <input type="checkbox"/> Anxiety              | <input type="checkbox"/> Ulcers           | <input type="checkbox"/> Tremors              | <input type="checkbox"/> Numb/Tingling in Arms/Hands |
| <input type="checkbox"/> Lower Back Pain | <input type="checkbox"/> ADD/ADHD             | <input type="checkbox"/> Digestive Issues | <input type="checkbox"/> Disc Problems        | <input type="checkbox"/> Numb/Tingling in Legs/Feet  |
| <input type="checkbox"/> Hip/Leg Pain    | <input type="checkbox"/> Loss of Balance      | <input type="checkbox"/> Diarrhea         | <input type="checkbox"/> Scoliosis            | <input type="checkbox"/> Stomach Problems            |
| <input type="checkbox"/> Knee Pain       | <input type="checkbox"/> Depression           | <input type="checkbox"/> Constipation     | <input type="checkbox"/> Poor Posture         | <input type="checkbox"/> Growing pains               |
| <input type="checkbox"/> Foot Pain       | <input type="checkbox"/> Allergies            | <input type="checkbox"/> Bed Wetting      | <input type="checkbox"/> Skin Problems        | <input type="checkbox"/> Difficulty Breathing        |

Other: \_\_\_\_\_

**Pregnancy Information:**

How was your pregnancy? \_\_\_\_\_

Any pregnancy complications? \_\_\_\_\_

Did you take any medication during your pregnancy? \_\_\_\_\_

Other information: \_\_\_\_\_

**Delivery Information:**

Location of Birth: (Circle One)      Hospital Birth Center      Home

Birth Intervention: (Circle One)      Forceps      Vacuum Extraction      Caesarian Section

Induced? Yes/No Explain: \_\_\_\_\_

Medications during delivery? \_\_\_\_\_

Other information: \_\_\_\_\_

**Post Birth Information:**

Birth Weight: \_\_\_\_\_ Birth Length: \_\_\_\_\_

Breast Fed: Yes/No How long? \_\_\_\_\_ Formula Fed Yes/No How Long? \_\_\_\_\_

Introduced Solid Foods at \_\_\_\_\_ Months

Food Allergies or intolerances: \_\_\_\_\_

Doses of antibiotics/prescription drugs your child has taken: Past 6 months \_\_\_\_\_ Total lifetime \_\_\_\_\_

Present prescription drugs/ dosage? \_\_\_\_\_

Over the counter drugs (Tylenol, cough syrup, laxatives, etc.) \_\_\_\_\_

List all surgical operations & years: \_\_\_\_\_

Has your child ever been knocked unconscious?     Yes     No      Fractured A Bone?     Yes     No

If yes to either of the above, please describe: \_\_\_\_\_

## Quadruple Visual Analogue Scale

Please circle the number that best describes the question asked. If you have more than one complaint, please answer each question for each individual complaint and indicate the score of each complaint.

EXAMPLE: No pain \_\_\_\_\_ Worst possible pain  
 0 1 2 3 **4** 5 6 **7** 8 9 10

1. How would you rate your pain RIGHT NOW?

0 1 2 3 4 5 6 7 8 9 10

2. What is your typical or AVERAGE pain?

0 1 2 3 4 5 6 7 8 9 10

3. What is your pain level at its BEST? (How close to 0 does your pain get at its best?)

0 1 2 3 4 5 6 7 8 9 10

What percentage of you're awake hours is your pain at its best? \_\_\_\_\_%

4. What is your pain level at its WORST? (How close to 10 does your pain get at its worst?)

0 1 2 3 4 5 6 7 8 9 10

What percentage of your awake hours is your pain at its worst? \_\_\_\_\_%

Practice Member Name: \_\_\_\_\_ Date: \_\_\_\_\_

## Activities Of Life

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITY:

EFFECT:

Holding Head Up  No Effect  Painful (can do)  Painful (limits)  Unable to Perform

Tummy Time  No Effect  Painful (can do)  Painful (limits)  Unable to Perform

Nursing  No Effect  Painful (can do)  Painful (limits)  Unable to Perform

Sitting Up  No Effect  Painful (can do)  Painful (limits)  Unable to Perform

Crawling  No Effect  Painful (can do)  Painful (limits)  Unable to Perform

Standing Alone  No Effect  Painful (can do)  Painful (limits)  Unable to Perform

Walking Alone  No Effect  Painful (can do)  Painful (limits)  Unable to Perform

Other: \_\_\_\_\_  No Effect  Painful (can do)  Painful (limits)  Unable to Perform

Other: \_\_\_\_\_  No Effect  Painful (can do)  Painful (limits)  Unable to Perform



**For A Minor/Child, Please Fill Out And Sign Below  
Written Consent For A Child**

Name of practice member who is a minor/child: \_\_\_\_\_

I authorize Dr. Nate DeJong and any and all Highest Health Chiropractic staff to perform diagnostic procedures, radiographic evaluations, render chiropractic care and perform chiropractic adjustments to my minor/child. As of this date, I have the legal right to select and authorize health care services for my minor/child. If my authority to select and authorize care is revoked or altered, I will immediately notify Highest Health Chiropractic.

Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship To Minor/Child: \_\_\_\_\_

**Notice of Privacy Practices Acknowledgement**

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physicians certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclose to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**X-Ray Authorization**

As your healthcare provider, we are legally responsible for your chiropractic records. We must maintain a record of your x-rays in our files. At your request, we will provide you with a copy of your x-rays in our files. Digital x-rays on a CD will be available within 72 hours of request on any regular practice hours day. Please note: X-rays are utilized in this office to help locate and analyze vertebral subluxations. The doctor of Highest Health Chiropractic does not diagnose or treat medical conditions; however, if any abnormalities are found, we will bring it to your attention so that you can seek proper medical advice.

By signing below you are agreeing to the above terms and conditions.

Print Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_