Highest Health chiropractic

# PEDIATRIC FORM

*Ages: Newborn-15 years*

**Today's Date:** _____

Name_____ Date of Birth____ /____ /____ Age_____ Male/Female

Address_____City_____State_____ Zip_____

Mother's Name:_____ Birthdate:_____-_____-_____ Phone: _____

Father's Name:_____ Birthdate:_____-_____-_____ Phone: _____

Email(s): _____

Siblings: _____

Pediatrician/Family MD: _____ Last Visit Date: _____-_____-_____

Reason for Medical Visit: _____

Who is financially responsible for services received? _____

What is the primary way you heard about us/who referred you?_____

What are all the ways you have heard about us or researched us? Please check all that apply.

- ☐ Highest Health Practice Member
- ☐ Non-Practice Member
- ☐ HHC Team Member (staff)
- ☐ Instagram
- ☐ Facebook
- ☐ Google
- ☐ HHC Website
- ☐ PX Website
- ☐ Other

**Current Health conditions**

What health condition(s) bring your child to be evaluated by a chiropractor? _____

_____

_____

When did the condition first begin? _____

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

If yes, which one: □ Chiropractor □ Medical doctor □ Other_____

Who?_____ When?_____ Results?_____

Is this condition: □ Getting worse □ Improving □ Intermittent □ Constant □ Unsure

What makes the problem **better**? _____

What makes the problem **worse**? _____

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Please list any drugs/medications/vitamins/herbs that your child is currently taking:

| Medication Name | Dosage | Frequency | Reason for taking |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |
| 6. | | | |

**Health Goals for your Child**

What are your top 3 heath goals for your child?

*1.*_____

*2.*_____

*3.*_____

What would you like to gain?

□ *Resolve existing condition*

□ *Overall Wellness*

□ *Both*

Has your child ever visited a chiropractor? □ Yes □ No

If yes, what is the name of the chiropractic facility?: _____

What is their specialty? □ Pain Relief □ Nutrition □ Subluxation based □ Other

**Pregnancy & Fertility Information:**

Any fertility issues? □ Yes □ No If yes, please explain._____

Did mother smoke? □ Yes □ No If yes, how often?_____

Did mother drink? □ Yes □ No If yes, how often?_____

Did mother exercise? □ Yes □ No If yes, please explain_____

Was mother ill? □ Yes □ No If yes, please explain_____

Any ultrasounds? □ Yes □ No If yes, please explain_____

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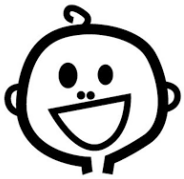

Any medications? □ Yes □ No If yes, please explain_____

Please explain any noticeable episodes of mental or physical stress during your pregnancy?

_____

Please explain any other concerns or notable remarks about your child's conception or pregnancy:

_____

**Labor & Delivery History:**

Child's birth was: □ Natural Vaginal Birth □ Scheduled C-section □ Emergency C-section

At how many weeks was your baby born? _____

Where was your child born? _____ Who delivered your baby?_____

Please indicate any applicable interventions or complications:

□ Breech □ Induction □ Pain meds □ Epidural □ Episiotomy

□ Vacuum extraction □ Forceps □ Other

Please describe any other concerns or notable remarks about your child's labor and/or delivery

_____

_____

Child's birth weight _____ Child's birth height _____

APGAR score at birth _____ APGAR score after 5 min _____

**Growth & Development History**

Is/was your child breastfed? □ Yes □ No

If yes, how long? _____

Did you have difficulty with breastfeeding? □ Yes □ No

Did they ever use formula? □ Yes □ No

If yes, at what age? _____ If yes, what type? _____

Did/does your child suffer from colic, reflux, or constipation? □ Yes □ No

If yes, please explain: _____

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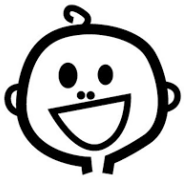

Did/does your child frequently arch their neck/back, feel stiff, or band their head? □ Yes □ No

If yes, please explain:_____

At what age did your child do the following:

| | Age | | Age |
|---|---|---|---|
| Respond to Sound | | Sit alone | |
| Follow an Object | | Crawl | |
| Hold head up | | Walk | |
| Vocalize | | Begin Cow milk | |
| Teething | | Begin Solid foods | |

Please list any food intolerance or allergies and when they began _____

_____

Please list your child's hospitalization and surgical surgery: _____

_____

Please list any major injuries, accidents, falls, and/ or fractures your child has sustained in his/her lifetime:

_____

Have you chosen to vaccinate your child? □ Yes, on a delayed schedule □ Yes, on schedule □ No

Has your child received any antibiotics? □ Yes □ No

If yes, how many times? Please provide a reason for the antibiotics. _____

_____

At what age did your child first use antibiotics? _____

Has your child experience night terrors or difficulty sleeping? □ Yes □ No

If yes, please explain _____

Does your child experience behavior, social, or emotional issues? □ Yes □ No

If yes, please explain _____

How many hours per day does your child typically spend watching TV, computer, tablet or phone?_____

Describe your child's diet:

□ mostly whole, organic foods □ pretty average □ high amount of processed foods

**Patient Review of Symptoms**

The nervous system controls and coordinates all organs and structures of the human body.

Please check the corresponding boxes for each system or condition you have experienced both past and present.

| | Past | Present | | Past | Present |
|---|---|---|---|---|---|
| Colic & Excessive Crying | | | Hyperactivity & impulsivity | | |
| Difficulty Latching/Nursing | | | Anxiety & Emotional instability | | |
| Reflux & Excessive Spit up | | | ADD/ADHD | | |
| Projectile Vomiting | | | Balance & Coordination issues | | |
| Frequent Stiffening, Rigidity, Arching | | | Visual & Auditory processing Challenges | | |
| Difficulty Sleeping | | | Low energy and Fatigue | | |
| Torticollis | | | Headaches/migraines | | |
| Plagiocephaly | | | Jaw, swallowing, sensory food Aversions | | |
| Motor Milestone Delays | | | Vision & hearing issues | | |
| Low tone & coordination Challenges | | | Allergies & autoimmune Challenges | | |
| Speech & Communication Delays | | | Ear infections | | |
| Sensory Processing Challenges | | | Sinus infections | | |
| Social/Emotional challenges | | | Gas pain & bloating | | |
| Frequent tantrums/meltdowns | | | Toe walking | | |
| Behavior issues | | | Asthma | | |
| Blood Sugar Issues | | | Bronchitis & Pneumonia | | |
| Swollen tonsils and Adenoids | | | Sore throat and Strep | | |

**Acknowledgment & Consent**

_____ _____-_____-_____

Legal Guardian's Signature Date Completed

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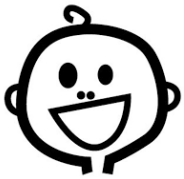

# QUADRUPLE VISUAL ANALOGUE SCALE

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 _____ Back pain Headaches _____ Worst possible pain

0 1 2 3 (4) 5 6 (7) 8 9 10

1. **How would you rate your child's pain RIGHT NOW?**

_____

0 1 2 3 4 5 6 7 8 9 10

2. **What is your child's typical or AVERAGE pain?**

_____

0 1 2 3 4 5 6 7 8 9 10

3. **What is your child's pain level at its BEST? (How close to zero does your pain get at its best?)**

_____

0 1 2 3 4 5 6 7 8 9 10

What percentage of your 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? _____%

_____ _____-_____-_____

Legal Guardian's Signature Date Completed

## WRITTEN CONSENT FOR A CHILD

I authorize the doctors, 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. I understand and accept that there are risks associated with chiropractic care and give consent to the examination that the doctor deems necessary and the chiropractic care, including spinal adjustments, as reported following my assessment. I authorize and request payment of insurance benefits directly to the doctors at Highest Health Chiropractic. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the practice member. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment. This pertains to any and ALL services rendered.

Acknowledge & Initial Here: _____

## 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.

Acknowledge & Initial Here: _____

## HIGHES HEALTH CHIORPRACITC PHOTO RELEASE

I grant Highest Health Chiropractic and its employees the right to take photographs of me with connections to the promotion of chiropractic via websites, social media, and any other avenues. I agree that Highest Health Chiropractic may use such photographs of me and for any lawful purpose, including such purpose as publicity, illustration, advertising, and web content.

Acknowledge & Initial Here: _____

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## NO CALL NO SHOW POLICY

In our office we reserve our time to serve you and your family. We understand that life happens, and appointments may need to be changed or canceled for emergent reasons. In this event we request that you give our office a call ASAP to change your scheduled appointment OR use your SKED appt. on your phone. We base our schedule and staffing needs on the anticipation of everybody making their appointments, making each scheduled appointment very important. Most importantly, it affects our committed practice members and others who rely on their scheduled time and who could have taken someone else's missed appointment spot. TWO "no call no shows" for regular adjustments are granted to a practice member in the event of an emergency, but there is no tolerance for chronic "no call no shows". Following the 3rd "no call no show" our billing department will automatically apply a $25 "no call no show" fee to the credit/debit card on file per family member at the end of the business day. For special appointment codes that require an evaluation room and a team member (Example: reevaluations, x-rays, Annual Health Reviews, etc.) our billing department will automatically apply a $25 "no call no show" fee to the credit/debit card on file per family member at the end of the business day for all missed special appointments. Ultimately, being consistent with your care will yield the best results for your health.

- I understand the above cancellation policy as well as the penalty fees that may be applied to my credit/debit card.

Acknowledge & Initial Here: _____

## 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. Upon request, your x-rays can also be available for an additional $5 cost. 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: _____

Legal Guardian's Signature: _____ Date: _____

Relationship To Minor/Child: _____

*By signing below, I am acknowledging and consenting myself or my minor/child to the above initialed sections (Notice of Privacy Practices Acknowledgement, Informed Consent for Chiropractic Care, & Photo Release)*

_____ _____-_____-_____

Practice Member or Authorized Person's Signature Date Completed

Doctor Use Only

I am acknowledging that I have reviewed and discussed the health history of this practice member.

Doctor Signature _____