Child History Form

Date: _____

Please complete this detailed history form and return it to the receptionist. Should you require any assistance, please let us know as we will be happy to assist.

Child's Name: _____ Home telephone: _____

Address: _____

_____ Postal Code: _____

Doctor's Name: _____ Doctor's Address: _____

Name of Previous Doctor of Chiropractic: _____

Date of Last Visit (dd/mm/yyyy): _____

Child's Height: _____ Child's Weight: _____

Name(s) of Parent(s) or Guardian(s): _____

Business Telephone: _____

I hereby authorize and consent to the chiropractic evaluation and care of my child.

Parent or Guardian Signature: _____ _____

Witness: _____

What are your chief concerns, if any, with your child's health?

_____

_____

What is your main reason for contacting us?

_____

_____

List any other care your child has undergone with regards to this complaint including medication:

_____

_____

Date of onset (mm/yyyy): _____

Onset was: (circle one)
Sudden Gradual Associated with an event

Duration of problem or episode: (circle one)
Minutes Hours Days Months Years

Pattern of Problem: (circle one)
Constant Intermittent Occasional Cyclical

Initiating Factors: _____

Aggravating Factors: _____

Relieving Factors: _____

How does the problem affect your child's body function and daily activities?

_____

Prior occurrence or episodes? _____

Other health concerns? _____

History of Birth

Hospital / Birthing Center: □ Home □ Medical □ Midwife Duration of Gestation: _____ weeks

Was the birth assisted? □ Yes □ No If yes, how? □ Forceps □ Vacuum Extraction □ C-Section □ Induced Labour

Were medications given to the mother at birth? □ Yes □ No If yes, what? _____ Duration of Birth: _____

Was the delivery normal? □ No □Yes If no, what complications were there at birth? _____

APGAR at Birth _____ APGAR after 5 minutes _____ Birth Weight _____ Birth Length _____

Growth and Development

Was the infant alert & responsive within 12 hours of the delivery? □ Yes □ No If no, explain: _____

At what age did the child: Respond to sound? _____ Follow an object? _____ Hold up head? _____ Vocalize? _____

Sit alone? _____ Teethe? _____ Crawl? _____ Walk? ____ Do his/her sleeping patterns seem normal? □ Yes □ No

Describe any health problems that exist on the mother's side of the family? (e.g. Cancer, Diabetes etc.) _____

_____

The father's side? _____

Do the child's siblings have any health problems? □ Yes □ No If yes, describe: _____

The following information is very important because many of the problems that chiropractors work with are caused by stressors.

Chemical Stressors

During pregnancy, did the mother: 1. Smoke □ Yes □ No 2. Drink alcohol? □ Yes □ No 3. Take supplements/vitamins? □ Yes □ No

4. Take drugs? □ Yes □ No If yes, what? _____ 5. Become ill? If so, how? _____

5. Receive ultrasounds? □ Yes □ No If yes, how many?_____ 6. Receive invasive procedures (ie. amniocentesis, CVS)? □ Yes □ No

Was your child breast fed? □ Yes □ No If yes, for how long? _____ weeks months years

At what **age** was: 1a. Formula introduced? _____ b. Brand? _____ 2. Cow's milk? _____ yrs 3. Solid foods? _____ yrs

Did your child receive vaccinations? □Yes □ No If yes, which ones? _____ Did your child react to them? □Yes □ No

Has your child had antibiotics? □ Yes □ No If yes, how many courses has the child had so far & why? _____

Any pets at home? □ Yes □ No Any smokers at home? □ Yes □ No If yes, how much? _____

Psychological Stressors

Any difficulties with lactation? □ Yes □ No Any problems bonding? □ Yes □ No Does your child seem normal to you? □ Yes □ No

Does the child have any behaviour _____

problems? □ Yes □ No If yes, what? _____

Does your child have difficulties sleeping (e.g. night terrors, sleepwalking, etc.)? □ Yes □ No If yes, specify: _____

Did your child go to daycare? □ Yes □ No From what age? _____ yrs Average no. of hours of TV/Computer per week? _____ hrs

Traumatic Stressors

Any evidence of trauma during birth? □ Bruises □ Odd shaped head □ Stuck in birth canal □ Fast and/or excessively long birth

□ Respiratory Depression □ Cord around neck □ Other _____

Any falls/accidents during pregnancy? □ Yes □ No Has the child had any major falls since birth? □ Yes □ No If yes, did the child need stitches or cause a fracture? Please describe: _____

Any hospitalizations? □ Yes □ No Please explain: _____

Does your child play sports? □ Yes □ No Number of hours per week? _____ Age child began _____ yrs

Weight of school backpack? _____lbs Approx. Hours spent at play per week? _____ hrs

Office Policies

Financial

Dr. Pietrantone does not participate (not in-network) with any insurance. As a courtesy, we submit claims to your insurance for you, unless you would prefer to bill your insurance yourself. Payments made by the insurance company, will be mailed directly to the patient, (by the insurance company). We are unable to fill out any paperwork for approvals, authorizations, etc. This would become too overwhelming if we had to do this for all patients. Billing your out-of-network benefits is a courtesy and does not guarantee coverage and reimbursement. This depends solely on your insurance plan's coverage and limits.

All payments for appointments are due at the time of the visit.

All supplements and additional supplies are the patient's responsibility and payment is due at the time of the visit.

Because we value the time spent with our patients, appointments that you make are reserved solely for you and the doctor. Please give our office at least 24 hours advance notice for any cancellation. If 24 hours notice is not given 50% of the appointment fee will be billed you. You will not be able to schedule subsequent appointments if you have an outstanding no-show balance.

We accept all major credit cards, FSA cards, HSA cards, cash and checks.

Emergencies

If you have a medical emergency and are unable to contact us through the office phone, 716-800-7161, please go to the Emergency Room or dial 911.

Confidentiality

We will never sell your information such as emails or phone numbers. Any requests for documentation by doctors, family, and insurance companies will require your written consent.

By signing below you understand and agree to the above office policies including the 24-hour cancelation fee. Bring this form to your first appointment. We cannot begin treatment without it.

Name(printed)_____

Name(signed)_____ Date_____

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