

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

Dr. Luke Pietrantone and Dr. Michelle Pietrantone are Chiropractors, and not medical or osteopathic physicians. As a result, this practice and the care provided is limited to that which is permitted by State Law. We do not provide the type of care or treat conditions that fall within the scope of practice of Medical Doctors, and do not treat or offer cures for diseases or illnesses, only nutritional advice or support. It is understood that this advice and support is provided for general health and is not offered as treatment for a specific disease or illness.

Financial

Dr. Luke and Dr. Michelle Pietrantone do not participate (not in-network) with any insurance. We will provide you with a receipt with the appropriate diagnosis codes and procedure codes upon request to the front desk. We are unable to fill out any paperwork for approvals, authorizations, etc. Patients may opt to submit this to their insurance on their own. However, any reimbursement depends solely on your insurance plan's coverage and limits.

All payments for appointments are due at the time of the visit. We accept all major credit cards, FSA cards, HSA cards, cash and checks.

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

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.

Emergencies

If you have a medical emergency and are unable to contact us through the office phone, 716-655-1421, 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 cancellation fee. Bring this form to your first appointment. We cannot begin treatment without it.

Name(signed)_____ Date_____

Pietrantone Chiropractic
121 Elm St.
East Aurora, NY 14052