CONFIDENTIAL PEDIATRIC HEALTH HISTORY

Please PRINT clearly.

Today's Date:

PATIENT INFORMATION

Name: (Last, First, MI) _____**Birth Date**:_____

Address: _____**City**: _____ **State**: _____**Zip**: _____

Mother: _____ **Phone**: _____

Father: _____ **Phone**: _____

INFANTS AND NEWBORNS – HEALTH HISTORY

PRENATAL HISTORY

Name of Previous Chiropractor: _____

Birth Weight: **Birth Length**: **Full Term**? ❑ No ❑ Yes *(Describe):*

Complications during pregnancy? ❑No ❑ Yes *(Describe):*

Medications during pregnancy or delivery? ❑ No ❑ Yes *(List)*:

Cigarette/Alcohol/Drugs during pregnancy? ❑No ❑ Yes *(List)*:

Birth Interventions? ❑ No ❑ Forceps ❑ Vacuum ❑ Caesarian ❑Other

FEEDING HISTORY

Breast fed? ❑No ❑ Yes *(How Long?)* **Formula fed?** ❑ No ❑ Yes *(How Long?)*

Introduced to cereal at _____ months old. **Introduced to solids at ____ months old**.

Food/Juice allergies or intolerances? ❑No ❑Yes *(Describe):*

DEVELOPMENTAL HISTORY

Sleep *(Hours per Night?)* **Problems Sleeping?** *(Describe)*

HAS YOUR CHILD EVER SUFFERED FROM: (*Check all that apply)*

Pediatric

- ❑ ADHD
- ❑ Allergies/Asthma
- ❑ Autism
- ❑ Back/Neck Pain
- ❑ Bed Wetting
- ❑ Behavioral issues
- ❑ Chronic Earaches
- ❑ Colic
- ❑ Constipation
- ❑ Growing Pains
- ❑ Nightmares
- ❑ Reflux
- ❑ *None in this Category*

Childhood Diseases

- ❑ Chicken Pox: Age
- ❑ Measles: Age
- ❑ Meningitis: Age
- ❑ Mumps: Age
- ❑ Rubella: Age
- ❑ Tuberculosis: Age
- ❑ Whooping Cough: Age
- ❑ Other: Age
- ❑ *None in this Category*

Has your child been vaccinated?

❑ No ❑ Yes

(Any Adverse Reactions? – Describe:)

Current Medications:_____ Past Medications:_____

Surgeries: ❑ Ear Tubes left / right / both ❑ Tonsils / Adenoids ❑ Other: _____

CONSENT FOR TREATMENT OF MINOR

I hereby authorize Dr. _____or whomever he may designate as assistants to administer examinations and chiropractic care as deemed necessary to: (minor patient's name).

Printed Name Parent/Guardian:_____ Witness:_____ Date: _____

Signature Parent/Guardian:_____Date:_____

Consents

Consent to Bill/Collect Insurance: I consent, if I am using a third party for payment of my services (health insurance, auto accident insurance, worker's compensation insurance, Parent/Guardian, etc), to allow North OKC Chiropractic Clinic (Dr. Justin Atkinson) to submit all necessary information needed to receive payment for the services I received to these third parties. I further consent to accept assignment of payments from my insurance company to be paid directly to the clinic or doctor.

_____ _____
Patient/Guardian Signature Date

Consent to Examination and Treatment: I give the doctors and staff of North OKC Chiropractic clinic permission to perform all examinations, x-rays, and treatment deemed necessary by the doctor. I understand that some of these procedures may be performed by either the staff or the doctor.

_____ _____
Patient/Guardian Signature Date

HIPPA: A copy of the full Health Information Privacy Policy for our clinic can be requested at our front desk. In brief, it states that we will not give any information about you except as consented to above. The only people we give information to is parents/guardians if you are a minor or whomever is responsible for your bill (i.e. insurance company, third party, or attorney if you have one).

_____ _____
Patient/Guardian Signature Date

Clinical Summary Report (CSR): I understand that a clinical summary report is created after each visit for the purpose of EHR and is available for my review. At this time, I am asking North OKC chiropractic clinic to save these electronically for me and not print them out after each visit. I understand that, upon request, these reports are available to be printed or emailed to me for review.

_____ _____
Patient/Guardian Signature Date

Pregnancy Waiver (Women Only): By my signature below, I am stating that to the best of my knowledge, I am not pregnant nor is pregnancy suspected at this time.

_____ _____
Patient/Guardian Signature Date

By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my healthcare provider to employ a third-party automated outreach and messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balances due or other communications.

I consent to the receiving messages from the automated outreach and messaging system, when necessary.

_____ _____ _____
Name Patient/Guardian Signature Date