

CHIROPRACTIC
Columbia, Missouri**PEDIATRIC HISTORY FORM**

We welcome you and your family to our clinic, Advanced Physical Health. In order to help us better serve you, please complete the following information. We look forward to working with you to build better health for your family.

Child's Name: _____ Today's Date: _____

Birth Date: ____/____/____ Age: _____ Female/Male (Circle One)

S/S #: _____

Whom may we thank for referring? _____

Primary Guardian's Information

Name: _____ Relationship: _____

Cell Phone Number: _____ Secondary Number: _____

Email: _____

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

Occupation & Employer: _____

If you wish for us to submit to insurance, please present your card to the front desk staff member.

Child's Current Health History

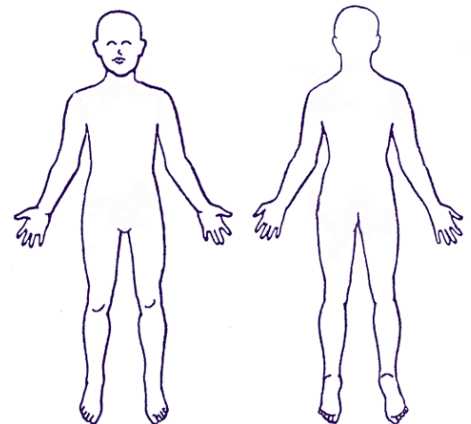
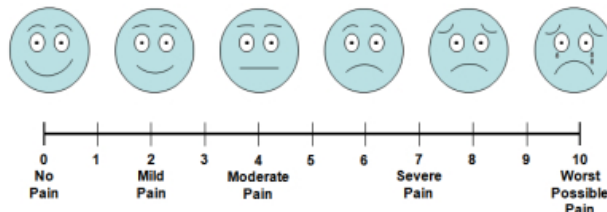
Reason(s) for care:

☐ Maintenance ☐ Improved Health ☐ Problem: _____

When did the symptoms appear: _____

Is the condition getting progressively worse? Y/N

*Please mark an X on the picture for the area of involvement.
Please circle the number along the scale that best describes the pain.*



CHIROPRACTIC
Columbia, Missouri

Please check any of the following conditions that apply:

<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Allergies	<input type="checkbox"/> Asthma	<input type="checkbox"/> Growing Pains
<input type="checkbox"/> Bed Wetting	<input type="checkbox"/> Chronic Colds	<input type="checkbox"/> Colic	<input type="checkbox"/> Autism
<input type="checkbox"/> Digestive Problems	<input type="checkbox"/> Ear Infections	<input type="checkbox"/> Headaches	<input type="checkbox"/> Seizures
<input type="checkbox"/> Recurring Fevers	<input type="checkbox"/> Reflux	<input type="checkbox"/> Scoliosis	

Other doctors seen for this condition (please include doctor's name, tests done and prior treatments):

Current: Weight _____ lbs. Height _____ ft. _____ in.

Developmental History:

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (bed, changing station, etc).

Did your child have a fall similar to what was described: **Y/N**

If yes please describe: _____

Have there been any other traumas? **Y/N**

Please list any injuries or accidents: _____

Date(s) of occurrence: _____

Has your child been involved in any sports? **Y/N**

Which sports: _____

Name of Pediatrician and last visit: _____

Has your child been seen by a physician on an emergency basis? **Y/N**

Number of doses of antibiotics your child has taken in the...

Past 6 months: _____ Total Lifetime: _____

Present prescription drugs/dosage: _____

Past prescription drugs/dosage: _____

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

Family history of significant spinal conditions:

CHIROPRACTIC

Columbia, Missouri

CHILDREN'S CONSENT

By signing below, I hereby request and give my consent for any physical examination, evaluation and the performance of procedures needed. The treatment many include chiropractic spinal manipulation and other physiotherapy modalities as necessary. I wish to rely on the doctors of Advanced Physical Health, PC to make those decisions about my care, based on the facts then known that she believes to be in my best interest. If the patient is a minor, by signing, I give consent for examination, testing and procedures for the minor.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my physician. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility. I have had an opportunity to discuss with the doctors of Advanced Physical Health, PC the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I authorize Advanced Physical Health, PC to release medical records required as is necessary. I understand that by signing below I give written consent for the use and disclosure of protected health information for treatment and health care operations.

Child's Name: _____ **Date:** _____

Parent/Guardian name: _____ **Signature:** _____

CHIROPRACTIC

Columbia, Missouri

Electronic Health Records Intake Form

In compliance with government requirements for EHR programs

First Name: _____ Last Name: _____

Email address of Parent/Guardian: _____

Preferred method of communication (circle one): **Email/Phone/Mail**

DOB: _____ Gender (circle one): **M/F**

Preferred Language: _____

CMS requires providers to report both race and ethnicity:

Race (Circle One): **American Indian or Alaska Native/Asian/African
American/Caucasian/Native Hawaiian or Pacific Islander/Other/Decline to
Answer**

Ethnicity (Circle One): **Hispanic or Latino/ Not Hispanic or Latino/Decline to
Answer**

Are you currently taking any medications (please include over the counter)

Medication Name Dosage and Frequency

Do you have medication allergies?

Medication Name Reaction Onset Date Additional Comments

☐ I choose to decline receipt of my clinical summary after every visit *(These summaries are often black as a result of the nature and frequency of chiropractic care)*

Patient signature: _____ Date: _____

Height: _____ Weight: _____ Blood Pressure: ____/____