Welcome to Awakening Chiropractic

Pediatric History Form

Today's Date: ____/_____/____ Home #_____ Cell#_____

Patient's Name: _____

Parents/Guardian Names:

_____

Mailing Address:

_____

City/State/Zip Code: _____

Parent's email address (for office announcements):

_____

Child's Birth Date: ___/___/___ Age: ___

Who can we thank for referring you to our office?

_____

Previous Chiropractic Care? Y N Prior Doctor of Chiropractic: _____

Please check reasons for pursuing chiropractic care for your child:

___ *I Recently had my spine checked and I see the value in getting my child checked.*
___ *I'm concerned about his/her health and I'm looking for answers.*
___ *She/He has a specific condition that concerns me.*
Explain condition of symptom:

_____

___*I want to improve my child's immune function.*
___*I have no idea why we're here. Please take the time to explain to me what you do for children.*

In order for us to better understand your child's current level of health, please check any of the following body signals which your child has or has had previously:

___Headaches	___Postural Imbalance	___Asthma	___Ear Infection
___Scoliosis	___ADD/ADHD	___PDD/Autism	___Seizures
___Growing/Back Pain	___Car Accident	___Digestive Problems	___Colic
___ Frequent Colds	___Sinus Problems	___Bedwetting	___Sleep Disorders

Other:

_____

List Prescription or Over The Counter Medications Currently Taking:

_____

Known Allergies: _____

Number of doses of **Antibiotics** your child has taken:
During the past 6 months: _____
Total during his/her lifetime: _____
List reasons: _____

Number of doses of other **Prescription Medications** taken:
During the past 6 months: _____
Total during her/his lifetime: _____
List medications: _____

Prenatal History:

Adopted? ____No ___Yes
Complications during pregnancy? ___No ___Yes

List: _____

Ultrasounds during pregnancy? ___No ___Yes How Many? _____
Medications/drugs/caffeine during pregnancy? ____No ___Yes

List: _____

Cigarette/Alcohol use during pregnancy? ___No ___Yes

Location of Birth: ___Hospital ___Birthing Center ___Home

Birth Intervention: ___All Natural/Mother Induced ___Mother Medicated (Pitocin, etc.)
___Caesarean Section ___Forceps ___Vacuum Extracted
___ Baby given medication after delivery: _____

Complications during delivery: ___No ___Yes

Explain:_____

Genetic Disorders or Disabilities? ___No ___Yes List: _____
_____
Breast Fed? ___No ___Yes How Long? _____ Formula Fed? ___No ___Yes How Long?_____

Food Allergies or Intolerances? ___No ___Yes

List:_____

According to the National Safety Council, approximately 50% of children fall head first from a high place during the first year of life (I.E., a bed, changing table, down stairs, etc.). Was this the case with your child?
___No ___Yes Explain:
_____

Is/Has your child been involved in any high impact or contact type sports (I.E., soccer, football, gymnastics, hockey, baseball, cheerleading, martial arts, basketball, etc.)? ___No ___Yes
List: _____

Has your child been seen on an Emergency Basis? ___No ___Yes
List:_____
Prior Surgery? ___No ___Yes
List: _____

It is important that our patients and we have the same health objectives concerning chiropractic care. Regardless of what a disease or condition is called we do not offer to treat it. Our only practice objective is to eliminate a major interference to the expression of the body's internal wisdom. Our only method is specific adjusting to correct vertebral subluxations. We believe that the greatest Doctor is the one already inside each of our patients and we only help to maximize that inherent healing power, without using drugs or surgery. Your signature verifies that the information given in this form is complete and correct and that you accept for your child, if eligible, chiropractic care on this basis.

_____ ___/___/___
(Parent/Guardian Signature) (Date)

Awakening Chiropractic, PLLC
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Privacy Policy

In order to provide you with care in our facility, you have provided personal information about yourself, some of which may be nonpublic in nature. We have a high regard for the privacy of our patients and want you to know how we handle your personal information. The following contains a description of the types of information we collect about you, and how the information is used and protected. This privacy statement describes our privacy practices for both our current and/or former patients.

Types and Sources of Information We Collect About You

We collect information about you, including nonpublic personal information, from the following sources:

- Information we receive from you on your case history form, as well as other forms related to your patient files.
- Information about your transactions with us, which may include your payments and payment history.
- Information we receive from your current and former physicians.
- Information we receive in reference to your current medical insurance policies.

Our Use of the Information That We Collect About You

We use the information we collect about you, including the nonpublic, personal information, only for the purposes of evaluating, effecting and administering, enforcing, and servicing your care with our facility. We do not disclose any non-public personal information about your to any non-affiliated third parties, except as provided by law. **We do not forward or otherwise share your information with anyone without prior written consent from you, the patient.**

Protection of Your Information

We restrict access to the nonpublic information about you to only necessary employees, unless requested from the patients themselves. Our facility has adopted an information security program that includes administrative, technical, and physical safeguards to protect the security and integrity of your nonpublic information.

_____ _____

Parent/Guardian Signature **Date**