SCHOOL-AGE CHILD HISTORY

(6 years of age and older)

Date: _____ Name of Mother: _____ Name of Father: _____

Name of child: _____ Sex: M F Date of Birth: ___/___/____ Age: ____

The reason for today's visit: _____

Yes No

☐ ☐ Does your child complain of pain or discomfort? If yes, when did this occur? _____

Was the onset sudden or gradual? _____

Is the problem constant or intermittent? _____

☐ ☐ Has your child ever had this problem before? _____

☐ ☐ Has your child previously been treated for this problem? By whom? _____

☐ ☐ Has your child previously had chiropractic care?

If yes, where? _____ If yes, by whom? _____

ABOUT YOUR HEALTH:

In the past year have you had any of the following?

☐ ☐ Back or neck pain? _____

☐ ☐ Pains in the arms or legs? _____

☐ ☐ Headaches? _____

☐ ☐ Asthma? _____

☐ ☐ Allergies? _____

☐ ☐ Earaches? _____

☐ ☐ Falls from a bicycle, skateboard, scooter, rollerblades or similar? _____

☐ ☐ Do you ever have a problem with bedwetting? _____

☐ ☐ Have you ever been in a motor vehicle accident? _____

☐ ☐ Have you ever had any broken bones? _____

☐ ☐ Have you ever had any surgeries? _____

☐ ☐ Are you presently taking any medications? _____

☐ ☐ Do you have any other health problems? _____

ABOUT YOUR LIFESTYLE:

What grade are you in at school? _____

How do you carry your schoolbooks? _____

How heavy is your school bookbag? _____

What sports do you play? _____

What hobbies do you have? _____

How many hours each day do you watch TV? _____

How many hours each day do you spend using a computer? _____

How often do you play video games? _____

On average, how many hours of sleep do you get each night? _____

☐ ☐ Are there any smokers in your family? _____

☐ ☐ Do you feel stressed out? _____

☐ ☐ Do you have trouble reading the board in class? _____

☐ ☐ Do you ever have blurred vision? _____

☐ ☐ Do you wear glasses or contact lenses? _____

☐ ☐ Do you sometimes get headaches when you read? _____

ABOUT YOUR DIET:

☐ ☐ Do you take vitamin supplements? _____

☐ ☐ Do you have a bowel movement each day? _____

☐ ☐ Do you have any persistent or intermittent occurring skin rashes? _____

☐ ☐ Do you have any food allergies? _____

What do you usually eat for Breakfast? _____

Lunch? _____ Dinner? _____

Snacks? _____ Favorite Food? _____

How much do you drink each day of: Water _____ Cow's Milk _____

Soda/Pop _____ Juice/Sports Drinks _____

What type of fast foods do you like to eat? _____

PATIENT INFORMATION

Date: _____
Patient Name: _____ Day Phone:_____
Address: _____ Night Phone:_____
City: _____ State:____ Zip:_____ Cell Phone:_____
Date of Birth: ___/___/___ Age: _____ Patient's Social Security Number: ____ - ____ -____
E-mail Address: _____
Mother's Name: _____ Occupation: _____
Father's Name: _____ Occupation: _____
Referred to this office by: Friend/Relative Yellow Pages Insurance Company Other

INSURANCE INFORMATION

Who is responsible for this account? _____
Insurance Company: _____
Group Number: _____ ID Number:_____
Subscriber's Name: _____ Employer: _____
Date of Birth: ____/____/___ Social Security Number: ____ - ____ - ____
Relationship to patient: _____

Is patient covered by additional insurance? Yes No
Insurance Company: _____
Group Number _____ ID Number_____
Subscriber's Name: _____ Employer: _____
Date of Birth: ____/____/___ Social Security Number: ____ - ____ - ____
Relationship to Patient: _____

Name of Pediatrician: _____ Location of Pediatrician_____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

I also hereby authorize Dr. _____ and whomever she may designate as assistants to administer chiropractic care as deemed necessary for _____ (name of child).

I give Dr. _____ permission to contact my child's pediatrician regarding his/her care? Yes No

_____ _____
Responsible Party Signature Relationship