WELCOME TO PEACE OF LIFE CHIROPRACTIC AT HALCYON VILLAGE!!!! Healing Happens Here

ABOUT THE CHILD

Name: ________________ Goes by: ___________

Birthdate: _________ Age: ______ Gender: ☐ F☐ M

Height: ________________ Weight: ___________

☐ Biological ☐ Adopted ☐ Foster ☐ Blended Family

Address: __________________________________

City/State/Zip: ____________________________

Mom's Name: ______________________________

Dad's Name: _______________________________

Best Phone #: ______________________________

Best Email: ________________________________

How did you hear about us? _________________

MOTHER'S PREGNANCY AND LABOR

During pregnancy did the mother:

- Take any medication? ☐ Yes ☐ No
  Explain:
  ____
- Smoke or Consume alcohol? ☐ Yes ☐ No
- Experience any illness? ☐ Yes ☐ No
  Explain:
  ____
  ____

Approximately how long did labor last? _________

Was labor chemically induced? ☐ Yes ☐ No

Was labor doctor assisted? ☐ Yes ☐ No

Was a C-Section performed? ☐ Yes ☐ No

Were forceps or vacuum used? ☐ Yes ☐ No

Was the baby pulled or twisted? ☐ Yes ☐ No

Was the delivery premature? ☐ Yes ☐ No

At birth, your child was:

_____ weeks gestation; _____ lbs; ______inches

Please check any of the following that your child experienced during or following birth:

- ☐ Jaundice
- ☐ Respiratory Problems
- ☐ Feeding Difficulty
- ☐ Displaced or Broken Joints
- ☐ Torticollis
- ☐ Shoulder Dystocia
- ☐ Lip/Tongue Tie
- ☐ Hospitalized for _____ days

REASON FOR VISIT

Describe the purpose of this visit:

____

____

When did this symptom begin? _______________

Is this symptom (mark all that apply):

☐ Getting worse ☐ Getting better ☐ No changes

☐ Comes and Goes ☐ Constant ☐ Frequent

☐ Infrequent ☐ Intensity varies

Does this symptom interfere with:

☐ Sleep ☐ Daily routine ☐ Appetite ☐ Digestion

☐ Breastfeeding ☐ Mood ☐ Comfort

Other: ____________________________________

What have you noticed about this symptom:_____

____

Has your child received any previous treatment for this symptom? ☐ Yes ☐ No

Type of treatment: __________________________

Results: ___________________________________

CHILD'S HEALTH HISTORY

Please check each of the conditions that your child has now or has had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis and course of care for your child.

☐ Vision Problems	☐ Chronic Infection
☐ Difficulty Latching	☐ Ear Problems
☐ Sleeping Disorders	☐ Bed Wetting
☐ Irritability	☐ Attention Problems
☐ Skin Problems	☐ Frequent Colds
☐ Difficult to Soothe	☐ Constipation
☐ Breathing Problems	☐ Digestive Problems
☐ Trouble Falling Asleep	☐ Hard to Stay Asleep
☐ Noisy while sleeping	☐ Straining to Eliminate
☐ Spitting Up	☐ Excessive Drool
☐ Clicking while feeding	☐ Reflux
☐ Colic	☐ Frequent Falls
☐ Food Sensitivity	☐ Failure to Thrive
☐ Sensitive Gag Reflex	☐ Startled Easily
☐ Developmental Delay(s)	☐ Speech Pathology

Is this your child's 1st adjustment? ☐ Yes ☐ No

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CHILD'S CURRENT HEALTH STATUS

What is in your child's diet? ___________________

____

Does your child feed from ☐Breast ☐Bottle ☐Utensil

Has your child:

- Been hospitalized ☐ Yes☐No
- Had a severe fall ☐ Yes☐No
- Been in a car accident ☐ Yes☐ No

Has your child ever taken antibiotics? ☐ Yes☐ No

How many rounds? ______ How often?_________

If your child currently taking any medication please list and explain: ___________________________

____

Does your child have difficulty interacting with schoolmates or friends? ☐ Yes☐No

Have your or anyone else noticed that your child is nervous, twitches, shakes or exhibits rocking behavior? ☐ Yes☐No

Has your child been vaccinated? ☐ Yes☐No

Which do you follow:
☐ Full Schedule
☐ Delayed Schedule
☐ Modified Doses
☐ Alternative Ingredient

Has your child experience any vaccine side effects?

☐Redness ☐ Lethargy☐ Rash ☐ Fever☐ Soreness

☐Diarrhea ☐ Joint Pain ☐ Swelling ☐ Vomiting

GOALS FOR MY CHILD

In your own words, describe the changes that you would like to see in your child: ________________

____

____

____

____

Children see chiropractors for a variety of reasons. At Peace of Life Chiropractic, we will weigh your needs and desires when recommending your child's chiropractic care program. Please check the benefits that interest you most so that we may be guided by your wishes whenever possible.

- ☐ Optimal digestion
- ☐ Balanced mood
- ☐ Improved learning
- ☐ Maximum coordination
- ☐ Cranial alignment/Head shape
- ☐ Amazing sleep
- ☐ Reach age-appropriate milestones
- ☐ Be more comfortable
- ☐ Pleasant breastfeeding experience
- ☐ Enhanced immune system

AUTHORIZATION TO CARE FOR A MINOR CHILD

I hereby authorize the Doctors at Peace of Life Chiropractic and whomever they may designate as their assistants to administer chiropractic care, to work with my child (Child's Name) ______________________________ through the use of adjustments and treatments to the head and spine, as the Doctors deems appropriate.

I have read and understand the Informed Consent document. Please consider my signature as acknowledgment that I have been informed of all risks and contraindications for an adjustment.

I understand and agree that only a parent or legal guardian can authorize chiropractic care, and must be present for all treatments. Service may be refused if your child is brought to their appointment without a parent or legal guardian.

I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment at the time of service. I agree that I am responsible for all bills incurred at this office. In the event a 3rd party is involved in the payment for services rendered, I understand that services denied or not paid at the rate anticipated remain my personal responsibility. The Doctors will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if my child's care is suspended or terminated, any fees for professional services rendered will become immediately due and payable.

_________________________	_________________________	________________
Print Parent/Guardian's Name	Parent/Guardian Signature Authorizing Care	Date

FINANCIAL INFORMATION

Payment in full is expected to be paid at time of service unless other arrangements have been made and agreed upon in writing prior to the service. Due to variations in insurance policy coverage and fee schedule changes, we can provide you with the most accurate quote of coverage over the phone or in person. Your payment type should be elected prior to service to help us ensure your expectations are met.

☐ Self-Pay ☐ Major Medical ☐ Medicare ☐ Individual–Name _____________ ☐ 3rd Party Co.–Name_____________

INSURANCE

We will need a copy of your driver's license and insurance card to keep on file

Name of Insurance Co. ______________________________ Policy # ________________________________

Name of Insured: _____________________ Insured DOB: __________ Relationship to Insured: ______________

Are you covered by more than one insurance company? Yes No Name of 2nd ____________________________

Is this visit related to an Auto Accident? ❑ Yes ❑ No

If yes, please DISCUSS WITH A PATIENT CARE REPRESENTATIVE and provide the following information:

Name of Auto Insurance Co: ____

Policy or Claim Number: ____

Has your child been treated elsewhere? ❑ Emergency Room ❑ Primary Care Doctor ❑ Other

What services were provided? ❑ MRI ❑ X-Rays ❑ Medication ❑ Therapy ❑ Other

PLEASE READ AND SIGN BELOW

The information I have provided on this case history form, is true and accurate to the best of my knowledge. I give the doctors permission to render care to me. I understand I am responsible for payment at the time of service. I have confirmed my payment election. I am aware this initial visit includes a health history/consultation, chiropractic exam/evaluation, and any initial care that is determined to be clinically necessary and mutually agreed upon.

I attest that all parents and/or legal guardians are in acceptance of chiropractic care and recommended services, written and verbal, comprehensively.

___________________________	___________________________	_______________
Print Parent/Guardian's Name	Parent/Guardian Signature Authorizing Care	Date

Thank you for choosing Peace of Life Chiropractic at Halcyon Village!!!

We look forward to enhancing your child's nervous system