



Pediatric History Form

It is a pleasure to welcome you and your family to Lakeway Spine Center. Please let us know if there is any way we can make you feel more comfortable. To help us serve you better, please complete the following information. We look forward to working with you to build better health for your family.

Patient Name: _____ SS#: ____ - ____ - _____

Name of Parents/Guardians: _____

Address: _____

City: _____ State: _____ Zip: _____ Home ph: _____

Parent Work Phone: _____ Email Address: _____

Birth Date: ____/____/____ Sex: M F Height: _____ Weight: _____

How did you hear about our office? _____

Reason for seeking Chiropractic care: _____

Other Doctors seen for this condition: Y N

Doctors' Names & Prior Treatments: _____

Other Health Problems: _____

Has your child ever suffered from: (Check all that apply)

- | | | |
|---|---|--|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Orthopedic Problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Broken Bones |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Seizures | <input type="checkbox"/> Car Accident: |
| <input type="checkbox"/> Ear Infections | <input type="checkbox"/> ADHD | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Asthma / Allergies | <input type="checkbox"/> Chronic Colds | |
| <input type="checkbox"/> Colic | <input type="checkbox"/> Headaches | |

Family Health History: _____

Previous Chiropractor: _____ Date of Last Visit: ____/____/____

Name of Pediatrician: _____ Date of Last Visit: ____/____/____

Are you satisfied with your child's care? ___Y___N Why? _____

Number of doses of **Antibiotics** your child has taken:

During the past 6 months: _____ Total during lifetime: _____

Number of doses of **Other Prescription Medications** your child has taken:

During the past 6 months: _____ Total during lifetime: _____



Prenatal History:

Name of Obstetrician / Midwife: _____

Location of Birth: Hospital Birthing Center Name: _____

Complications during Pregnancy: _____

Medications during pregnancy / delivery: _____

Cigarette / Alcohol use during pregnancy: Y N Both

Birth Intervention:

Forceps Vacuum Extraction C-section: Emergency or Planned

Complications during Delivery: _____

Genetic disorders or disabilities: N Y List: _____

Birth Weight: _____ Birth Length: _____

Breast Fed: N Y If so, for how long: _____ Months / Years

Formula Fed: N Y If so for how long: _____ Months / Years

Food / Juice Allergies or Intolerances: _____

Developmental History:

Number of hours sleeping per night: _____ Quality of sleep: Good Fair Poor

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? N Y If yes, approximate date: _____

Has your child ever been involved in a car accident? N Y Date: ___/___/___

Has your child been seen on an emergency basis? N Y Date: ___/___/___

Has your child been involved in any high impact or contact sports?
 N Y Type(s): _____ Duration: _____ Months / Years

Other traumas not described above: _____

Prior Surgery: N Y Type & Date: _____

Childhood Diseases: _____ Age: _____

Insurance:

Do you have medical insurance? N Y Insurance Company: _____

Policy Number: _____ Insurance Phone #: _____

Insured's Name: _____ Relationship to Patient: _____

Insured's DOB: ___/___/___ Insured's SS#: ___ - ___ - _____

**WE ARE HERE TO SERVE YOU AND ENCOURAGE YOU TO ASK QUESTIONS.
YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR RESULTS.**



Authorization for Care of Minor

I / We, the undersigned parent(s) and/or guardian(s) of:

_____ SS#: ____ - ____ - _____ ,

a minor, do hereby authorize this office and its doctors to administer chiropractic care and all appropriate therapies to my child, as they deem necessary.

Parent or Legal Guardian's Name (please print) Date

Parent or Legal Guardian's Signature Date

Witness Signature Date

Agreement for Payment of Services

By signing the authorization above, I affirm that I understand and agree that:

- ❖ Health and accident insurance policies are an arrangement between patients and their insurance carriers.
- ❖ This office will prepare any necessary reports and forms required by insurance companies for payment of services.
- ❖ Any amount that is authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse insurance payments to be applied to my account.
- ❖ All services rendered to me are charged directly to me and I am personally responsible for the payment of my account.
- ❖ It is the policy of Lakeway Spine Center to collect for services as they are rendered, unless other financial arrangements are made.