IGNITE CHIROPRACTIC

PEDIATRIC HISTORY FORM

Today's Date: _____ HR#: _____

PATIENT DEMOGRAPHICS

Child's Name: _____ Birthdate: _____-_____-_____ Age: _____ ○ Male ○ Female

Birth Height: _____ Birth Weight: _____ Current Height: _____ Current Weight: _____

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

Mother's Name: _____ Birthdate: _____-_____-_____

Mother's Phone: Home _____ Work _____ Mobile _____

Father's Name: _____ Birthdate: _____-_____-_____

Father's Phone: Home _____ Work _____ Mobile _____

Pediatrician/Family MD: _____ City/State: _____

Last Visit Date: _____-_____-_____ Reason for visit: _____

Who is responsible for this bill? _____

○ Father's Social Security #: _____-_____-_____ ○ Mother's Social Security #: _____-_____-_____

○ Father's Driver's License #: _____ ○ Mother's Driver's License #: _____

○ Other *(please explain)*: _____

CHILD'S CURRENT PROBLEM

Purpose of this visit: ○ Wellness Check-up ○ Injury or Accident ○ Other

Please explain: _____

If your child is experiencing **pain/discomfort, please identify where and for how long:**

_____

_____

1. When did the problem first begin? Date: _____-_____-_____ ○ Unknown ○ Gradual ○ Sudden
2. Has this problem occurred before? ○ No ○ Yes If yes, when? _____
3. Any bowel or bladder problems since this problem began? ○ No ○ Yes **If yes,** describe: _____

   _____
4. Have you seen any other doctors for this problem? ○ No ○ Yes **If yes**, whom? _____
5. How long ago? _____ Days _____ Weeks _____ Months _____ Years
6. What were the results of past treatment? _____
7. How is this problem NOW?

   ○ Rapidly Improving ○ Improving Slowly ○ About the Same ○ Gradually Worsening ○ On and Off
8. Please list any medication(s) taken for this problem: _____
9. Has your child ever sustained an injury playing organized sports? ○ No ○ Yes **If yes,** please explain:

_____

_____

PATIENT'S NAME: _____ HR#: _____ DATE: _____

10. Has your child ever sustained an injury in an auto accident? ○ No ○ Yes **If yes,** please explain:

_____

_____

HAS YOUR CHILD EVER SUFFERED FROM - *Check all that apply*

○ Headaches	○ Orthopedic Problems	○ Digestive Disorders	○ Behavioral Problems
○ Dizziness	○ Neck Problems	○ Poor Appetite	○ ADD/ADHD
○ Fainting	○ Arm Problems	○ Stomach Aches	○ Ruptures/Hernia
○ Seizures/Convulsions	○ Leg Problems	○ Reflux	○ Muscle Pain
○ Heart Trouble	○ Joint Problems	○ Constipation	○ Growing Pains
○ Chronic Earaches	○ Backaches	○ Diarrhea	○ Asthma
○ Sinus Trouble	○ Poor Posture	○ Hypertension	○ Walking Trouble
○ Scoliosis	○ Anemia	○ Colds/Flu	○ Sleeping Problems
○ Bed Wetting	○ Colic	○ Broken Bones	○ Fall off swing
○ Fall in baby walker	○ Fall from bed or couch	○ Fall from crib	○ Fall down stairs
○ Fall off bicycle	○ Fall from high chair	○ Fall off slide	
○ Fall from changing table	○ Fall off monkey bars	○ Fall off skateboard/skates	

○ Allergies to _____

○ Other: _____

I understand that I am directly and fully responsible to Ignite Chiropractic for all fees associated with chiropractic care my child receives.

The risks associated with exposure to ionization and spinal adjustments have been explained to me to my complete satisfaction, and I have conveyed my understanding of these risks to the doctor. After careful consideration, I do hereby request and authorize imaging studies and chiropractic adjustments for the benefit of my minor child for whom I have the legal right to select and authorize health care services on behalf of.

Under the terms and conditions of a divorce, separation or other legal authorization, the consent of a spouse/former spouse or other guardian is not required. If my authority to so select and authorize this care should change in any way, I will immediately notify this office.

_____ _____ - _____ - _____

Parent or Legal Guardian's Signature **Date Completed**

_____ _____ - _____ - _____

Doctor's Signature **Date Form Reviewed**

PATIENT'S NAME: _____ HR#: _____ DATE: _____

Authorization For Use Or Disclosure Of Photographic And/Or Video Images

Authorization:
I authorize the use and disclosure of my name, photographic/video images, and/or testimonial for marketing purposes by Ignite Chiropractic. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by HIPAA privacy regulations.

Purpose:
The photographic/video images and/or testimonial will be used for: *In-office material*, *Merchandise*, *Social Media and/or Advertising*

Revocability:
I understand that I may revoke this authorization at any time, but such revocation must be in writing and received by the practice in person or via registered mail. Revocation only affects disclosure moving forward and is not retroactive. This authorization expires 99 years from date signed.

No Treatment Conditions:
I understand that the practice cannot condition treatment on whether or not I sign this authorization.

Name _____
Date _____
Signature _____

If Personal Representative
Name _____
Date _____
Signature_____
Relationship to Practice member _____

If Practice member is a Minor
Parent Legal Guardian _____
Date _____
Signature _____