



Pediatric Form

Name _____ Date of Birth ___ / ___ / ___ Age ___ Male/Female
 Address _____ City _____ State _____ Zip _____
 Guardian(s) Name: _____ Relationship: _____
 Siblings: _____ Child's Social Security #: _____
 Phone Number: _____ Weight: _____ Height: _____
 Who may we thank for referring you? _____



List The Health Concerns That Brought You Into This Office



Health Concern: List according to severity. ↓	Rate of Severity 0 = no pain 10 = unbearable	When did this problem start?	Have you had the problem before? If so, when?	Did the problem begin with an injury?	Are symptoms constant (C) or intermittent (I)?
Primary: _____	_____	_____	_____	_____	_____
Second: _____	_____	_____	_____	_____	_____
Third: _____	_____	_____	_____	_____	_____
Fourth: _____	_____	_____	_____	_____	_____

Have you ever seen other doctors for these conditions? Yes No
 If Yes: Chiropractor Medical doctor Other _____
 Who? _____ When? _____ Results? _____

Please Mark "P" For In The Past OR Mark "C" For Currently Have:

- | | | | | |
|--|---|---|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Sinus Issues | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Bladder Problems | <input type="checkbox"/> Sleep Problems | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Jaw/TMJ Pain | <input type="checkbox"/> Ringing in the Ears | <input type="checkbox"/> Thyroid Issues | <input type="checkbox"/> Seizures | <input type="checkbox"/> Tight/Sore Muscles |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Asthma | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Sports Injury |
| <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Loss of Energy | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Infertility | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Arm Pain | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Joint Pain |
| <input type="checkbox"/> Upper Back Pain | <input type="checkbox"/> Double/Blurry Vision | <input type="checkbox"/> Nausea | <input type="checkbox"/> Epilepsy/Convulsions | <input type="checkbox"/> GERD/Gastric Reflux |
| <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Tremors | <input type="checkbox"/> Numb/Tingling in Arms/Hands |
| <input type="checkbox"/> Lower Back Pain | <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Digestive Issues | <input type="checkbox"/> Disc Problems | <input type="checkbox"/> Numb/Tingling in Legs/Feet |
| <input type="checkbox"/> Hip/Leg Pain | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Knee Pain | <input type="checkbox"/> Depression | <input type="checkbox"/> Constipation | <input type="checkbox"/> Poor Posture | <input type="checkbox"/> Growing pains |
| <input type="checkbox"/> Foot Pain | <input type="checkbox"/> Allergies | <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Skin Problems | <input type="checkbox"/> Difficulty Breathing |

Other: _____

Pregnancy Information:

How was your pregnancy? _____

Any pregnancy complications? _____

Did you take any medication during your pregnancy? _____

Other information: _____

Delivery Information:

Location of Birth: (Circle One) Hospital Birth Center Home

Birth Intervention: (Circle One) Forceps Vacuum Extraction Cesarean Section

Induced? Yes/No Explain: _____

Medications during delivery? _____

Other information: _____

Post Birth Information:

Birth Weight: _____ Birth Length: _____

Breast Fed: Yes/No How long? _____ Formula Fed Yes/No How Long? _____

Introduced Solid Foods at _____ Months

Food Allergies or intolerances: _____

Doses of antibiotics/prescription drugs your child has taken: Past 6 months _____ Total lifetime _____

Present prescription drugs/ dosage? _____

Over the counter drugs (Tylenol, cough syrup, laxatives, etc.)

List all surgical operations & years: _____

Has your child ever been knocked unconscious? Yes No Fractured A Bone? Yes No

If yes to either of the above, please describe: _____

Quadruple Visual Analogue Scale

Please circle the number that best describes the question asked. If you have more than one complaint, please answer each question for each individual complaint and indicate the score of each complaint.

EXAMPLE: No pain Ear Infection Headaches Worst possible pain
 0 1 2 3 4 5 6 7 8 9 10

1. How would you rate your pain RIGHT NOW?

0 1 2 3 4 5 6 7 8 9 10

2. What is your typical or AVERAGE pain?

0 1 2 3 4 5 6 7 8 9 10

3. What is your pain level at its BEST? (How close to 0 does your pain get at its best?)

0 1 2 3 4 5 6 7 8 9 10

What percentage of you're awake hours is your pain at its best? _____%

4. What is your pain level at its WORST? (How close to 10 does your pain get at its worst?)

0 1 2 3 4 5 6 7 8 9 10

What percentage of your awake hours is your pain at its worst? _____%

Activities Of Life

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

<u>ACTIVITY:</u>	<u>EFFECT:</u>			
Holding Head Up	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Tummy Time	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Nursing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sitting Up	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Crawling	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Standing Alone	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Walking Alone	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Other: _____	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Other: _____	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform

LIST RESTRICTED ACTIVITY

CURRENT ACTIVITY LEVEL

USUAL ACTIVITY LEVEL

**For A Minor/Child, Please Fill Out And Sign Below
Written Consent For A Child**

Name of practice member who is a minor/child: _____

I authorize Dr. John Jones and any and all Paramount Health Chiropractic staff to perform diagnostic procedures, radiographic evaluations, render chiropractic care and perform chiropractic adjustments to my minor/child. As of this date, I have the legal right to select and authorize health care services for my minor/child. If my authority to select and authorize care is revoked or altered, I will immediately notify Paramount Health Chiropractic.

Guardian Signature: _____ Date: _____

Relationship To Minor/Child: _____

Notice of Privacy Practices Acknowledgement

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physicians certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclose to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

Signature: _____ Date: _____

X-Ray Authorization

As your healthcare provider, we are legally responsible for your chiropractic records. We must maintain a record of your x-rays in our files. At your request, we will provide you with a copy of your x-rays in our files. Digital x-rays on a CD will be available within 72 hours of request on any regular practice hours day. Please note: X-rays are utilized in this office to help locate and analyze vertebral subluxations. The doctor of Highest Health Chiropractic does not diagnose or treat medical conditions; however, if any abnormalities are found, we will bring it to your attention so that you can seek proper medical advice.

By signing below you are agreeing to the above terms and conditions.

Print Name: _____ Date of Birth: _____

Signature: _____ Date: _____