

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

NAPLES HEALTH INSTITUTE

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:

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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*

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

Other:

I understand that I am directly and fully responsible to **UPWARD SHIFT 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 my 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 TO CONSENT TO TREATMENT

Dear Parent(s):

State law requires that you consent to most medical treatments for your minor child.

If an adult other than your child's parent or legal guardian accompanies him/her to office visits, we will be unable to provide treatment without your written authorization, except in emergency situations.

To authorize an adult other than your child's parent or legal guardian to consent to medical treatment for your child, please complete the sections below. By completing this authorization, you consent to the sharing of your child's protected health information with this individual as outlined in our Notice of Privacy Practices.

AUTHORIZATION

I, _____ authorize the following individual(s),
(Name of Parent or Legal Guardian)

Name: _____ Relationship to child: _____

Name: _____ Relationship to child: _____

to consent to medical treatment for my minor child/children listed below:

Name: _____ Date of birth: _____

Name: _____ Date of birth: _____

Name: _____ Date of birth: _____

Name: _____ Date of birth: _____

LIMITATIONS

Identify any limitation on the kinds of medical services for which this authorization is given. If none are specified, no limitations will be applied.

Identify any limitations on the time frame for which this authorization is given. If none are specified, no limitations will be applied.

PARENTAL CONTACT INFORMATION

If the nature of the medical care is not routine, please try to contact me (us) regarding the health care of my (our) children at the following telephone number(s). If you are unable for any reason to contact me (us), you may rely on the proxy decision maker for consent.

Parent's Name: _____

Parent's Name: _____

Daytime Phone: _____

Daytime Phone: _____

Evening Phone: _____

Evening Phone: _____

Cell Phone: _____

Cell Phone: _____

Signature of Parent or Legal Guardian

Date