#______

Pediatric History Form

Date: ________________

Patient Name: ____ SS#:______________________________Age: ________

Name of Parent/Guardian: ____ Phone#:_________________________________

Address: ____ City: ______________________State:______ Zip: ___________

Sex: Male Female Height: _____________ Weight: ____________ Date of Birth: ______________________

I would you like Text/ Email reminders Yes / No Email: ____

Phone carrier? _____________________ How did you hear about us? _____________________________________

Reason for seeking care: ____

Other Doctors seen for this condition: ____

Other health problems: ____

Check any of the following conditions your child has experienced in the last 6 months:

Ear Infections	Seizures	ADHD/ADD	Headaches	Anger Issues
Asthma	Bed Wetting	Chronic Colds	Back Pain	Sleeping problems
Allergies	Digestion Issues	Recurring Fevers	Neck Pain	Other:
Colic	Scoliosis	Growing Pains	Temper Tantrums	________________

Medication taken in the last year: ____

Previous Chiropractor: ____

Name of Pediatrician: ____

Is your child currently taking: Antibiotics? Yes/No Prescription Drugs? Yes/No

Has your child been vaccinated? Yes/No If yes, which ones: ____

Do you have insurance? Yes / No ***If yes, Please give your card to the front desk***

Doctor's Notes Only

Daily:	______	**Initial:**	____	Extr:	______
4xs:	______	**Cerv:**	____	F/U:	______
3xs:	______	**Thor:**	____	Trxn:	______
2xs:	______	**Lum:**	____	Exer:	_____
1x:	______	**ADJ:**	____		
E-O:	______				
Mth:	______				

Prenatal History:

Complications during pregnancy:____

Ultrasounds during pregnancy: If yes, how many: ____

Medications taken during pregnancy/delivery: ____

Supplements taken during pregnancy: ____

Cigarette/Alcohol use during pregnancy: If yes, how often: ____

Location of birth: Hospital Birthing Center Home

Birth interventions: Forceps Vacuum Extraction Caesarian Section Epidural None

Complications during delivery: ____

Genetic disorders or disabilities: ____

Birth Weight: ___________ Birth Length: ______________

Breast Fed: Yes/No How long: __________________ Formula Fed: Yes/No How long:_____________________

According to the National Safety Council, approximately 50% of children fall head first from a high place during the first year of life (ie: bed, changing table, downstairs, etc.) Was this the case with your child? If yes, Please describe:
____

Has your child been involved in any high impact or contact sports? (ie: soccer, football, gymnastics, baseball, martial arts, etc.) If yes, which ones: ____

Has your child ever been involved in a car accident: ____

Other traumas not described above: ____

Surgeries: ____

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and me. Furthermore, I understand that this office will prepare any necessary reports and form to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to may account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand than agree that all services rendered me are charged directly to me and I am personally responsible for payment. It is my understanding that my credit may be check if Clear Chiropractic extend credit to me and I understand that if I suspend or terminate my care and treatment, and fee for professional services rendered to me will be immediately due and paid unless other arrangement are made. I hereby authorize the doctors and massage therapists at Clear Chiropractic and whomever they may designate as their assistants, to administer treatments as they so deem necessary and also authorize the release of any information acquired in the course of examination or treatment. I certify that the above information is true and correct.

As legal parent/guardian of ______________________________, I hereby give my permission to Clear Chiropractic to render Chiropractic services to the above named minor. (A minor is any dependent under the age of 18 years old.)

Parent/Guardian Name ______________________________

Parent/Guardian Signature_______________________________________
date

Pain Index Questionnaire

In the last (week/month),

How many days did your child *miss school* due to (this health problem)? .... __

How many days did you *reduce their normal activities* due to (this health problem)? .... __

How many days did they *stay in bed more than half a day* due to (this health problem)? .... __

How many days have they felt very healthy and full of energy? .... __

Global Well Being Scale

Please think about your child's general sense of health and well-being. On the line below, make a straight line (up-and-down) to show how they feel right now.

WORST YOU COULD POSSIBLY FEEL |——————————| **BEST YOU COULD POSSIBLY FEEL**

Numeric Rating Scale

On a scale of 0 to 10, where "0" is "no pain" and "10" is the worst pain imaginable, please check the number that represents their pain right now.

NO PAIN ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10 **WORST PAIN**

Specific Activities

(use activity limitation scale for each one.)

Are there activities they can't do or have trouble doing due to this health concern? Please list. (examples: breastfeeding, sleeping, eating, crawling, walking, playing, going to school, etc.)

_______________________________________ _______________________________________

Activity Limitation

How much did this health concern **limit** their daily activities **in the last week**?

Activities are not limited ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10 Can't do daily activities at all

Patient Name (please print) ____

Patient Signature **Date** **Guardian Signature** **Date**

CLEAR CHIROPRACTIC Upper Cervical Care

Notice of Office Policies, Privacy Practices and Terms of Acceptance

I, ______________ have read and agree with the associated pages in regards to my care with Clear Chiropractic Spokane and have read the attached pages. (Pages present in office and copies are available upon request.)

_________ (initial) I have read and agree with the Clear Chiropractic **Office Policies**. Our office requires at least 24 hours of notice so that the provider may see others in need. It is recommended that all missed appointments be made up later in the same day or within 7 days to help you stay on track with your health care goals. **NOTICE:** Any appointments missed without proper notification, will be subject to a **($25/Chiropractic)** fee due at your next visit. You are always able to call and leave a message outside of office hours to reschedule.

_________ (initial) I have read and agree with the **Notices of Privacy Practices** and understand that it is required by law to maintain the privacy and confidentiality of your protected information. You have the right to a paper copy of this Notice of Privacy practices upon request.

__________(initial) I have also read and agree with the **Terms of Acceptance**. I understand that the only practice objective at Clear Chiropractic is to eliminate a major interference to the expression of the body's innate wisdom. This method is specific adjusting to correct vertebral subluxations.

I have read and fully understand the above statements.

Print Name: _______________________________ Date: _____________

Signature: ____

Print Name: ________________________________ Date: _______________

(Guardian name if under 18)

Your health is of the utmost importance to us, and we want you to get the most out of your chiropractic care. If you have any questions, about office policies or appointments, DO NOT hesitate to ask. We are here for you!