NATURAL HEALTH FAMILY CHIROPRACTIC
103 Sharlene Road
Ithaca, New York 14850
(607)277-1468

Pediatric Information

Name (full name please) _____ Date _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____Home Phone _____ Cell Phone (Parent's)_____

Age _____ Gender _____ Height _____ Weight _____ Ages of Siblings _____

Has child had chiropractic care before? Y N DC's Name _____

Child's medical doctor and address _____

Date of last doctor's visit _____ Reason _____ Referred by_____

Parent's email address _____

Prenatal and Delivery History

Prenatal care? Yes No Chiropractic care through pregnancy? Yes No

Any trauma or possible toxic exposure during pregnancy? _____

List any complications during pregnancy. _____

Gestation of pregnancy _____ Place of birth _____

Type of Delivery: Vaginal C-Section Breech Hours of labor_____

List any complications during delivery (forceps, vacuum, cord problems, etc.) _____

_____

List any medications taken during delivery _____

Apgar scores _____ Weight at birth _____ Length at birth_____

List any concerns at birth (nursing, breathing, color, etc.) _____

_____

List any procedures performed at birth to Mom or Baby (surgery, artificial feeding, etc.) _____

_____

Nutritional History

Breastfed?_____ Duration_____ Formula – type and when started_____

Cow's milk began at age _____ Other milk? Y N Type:_____ Age_____ Solid food began age _____

Were commercially prepared baby foods used? _____ Food intolerance? Y N Type:_____

General Health History

Typical sleep patterns (day and night)_____

Age when started… Teething_____ Rolling_____ Crawling_____ Walking_____

Climbing_____ Babbling/Talking_____

List any immunizations and any reactions observed_____

_____

List any significant family history (asthma, cancer, diabetes, etc.)_____

_____

List any other significant information_____

_____

History of Concern

Reason for contacting us _____ Date of onset _____

How did symptoms start? *Sudden* *Gradual* Are symptoms - *Constant* *Intermittent* *Occasional*

Initiating factors _____

What makes the concern better? _____

What makes the concern worse? _____

Has this interfered with your child's daily activities? In what way? _____

What do you believe caused this concern? _____

Authorization to Treat Minors

I, _____, give my consent to Drs. Gerrit Van Loon, PT, DC and/or Meghan Van Loon, PT, DC, DICCP to evaluate and treat my son/daughter, _____.

_____ _____

Authorized Signature Date

Photo Authorization

I give Natural Health Family Chiropractic authorization to photograph my child _____ with the understanding that the photos will not be used or displayed outside of the NHFC office located at 103 Sharlene Road, Ithaca.

_____ _____

Authorized Signature Date

Payment and Insurance Information

Payment is expected at the time of each visit.

If you are intending to submit any claims for reimbursement to an insurance company, please read and sign this. Additionally, if you will be filing a **No Fault** (auto accident) claim, please fill out the appropriate questionnaire.

I, _____ am responsible for payment and I understand and agree that health and accident insurance policies are arrangements between an insurance carrier and myself. I understand that **Natural Health Family Chiropractic** will complete the appropriate part of any necessary forms and provide any required reports to assist me in making collections from my insurance company. I understand that any amount paid to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment.

_____
Signature

Please fill in information as <u>completely</u> as possible so insurance claims are <u>accurate</u>.

Name of policy holder _____ Relationship to patient _____

Policy holder's address (if different from patient's) _____

Phone# _____ Date of birth _____

Policy holder's employer (and address) _____

_____

Insurance Company _____ Insured's ID number _____

Insurance Company's address _____

_____

Insurance Company's Phone # _____ Fax# _____