

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

**Pediatric Information**

Nine Months – Two Years

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 \_\_\_\_\_

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**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 concerns at birth (nursing, breathing, color, etc.) \_\_\_\_\_  
\_\_\_\_\_

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**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: \_\_\_\_\_  
Does your child have any food intolerances or allergies? Type? \_\_\_\_\_  
Does your child have any persistent or intermittent skin rashes? \_\_\_\_\_  
Is your child receiving any vitamin supplements? \_\_\_\_\_

## General Health History

Typical sleep patterns (day and night) \_\_\_\_\_

Age when started... Teething \_\_\_\_\_ Rolling \_\_\_\_\_ Crawling \_\_\_\_\_ Walking \_\_\_\_\_

Climbing \_\_\_\_\_ Babbling/Talking \_\_\_\_\_ Sitting Up \_\_\_\_\_

Has your child had colic? \_\_\_\_\_ Asthma? \_\_\_\_\_ Upper respiratory infections? How often? \_\_\_\_\_

Does your child complain of pain in back, neck, arms, or legs? \_\_\_\_\_

Does your child complain of headaches? \_\_\_\_\_

Has your child had any earaches? How often? \_\_\_\_\_ At what age did the earache first occur? \_\_\_\_\_

Do your child's earaches tend to occur in the same ear? \_\_\_\_\_ Right Left Both

List approximate date of any other illnesses \_\_\_\_\_

Is your child receiving any medications? \_\_\_\_\_

List any immunizations and any reactions observed \_\_\_\_\_

Has your child had any illnesses or injuries that have required hospitalization or surgery? \_\_\_\_\_

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

Has your child had any recent falls or trauma? \_\_\_\_\_

Has your child fallen down stairs or from any height? \_\_\_\_\_

Has your child been in a motor vehicle collision or near-miss? \_\_\_\_\_

Has your child had a bone fracture or joint dislocation? \_\_\_\_\_

Does your child bang his/her head repeatedly against a wall, bed, or other object? \_\_\_\_\_

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## 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

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**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

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**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

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**Please fill in information as completely as possible so insurance claims are accurate.**

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# \_\_\_\_\_