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

Pediatric Information

3 years – 13 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? Yes ❑ No ❑ DC's Name ____________________________

Child's medical doctor and address ____

Date of last doctor's visit _________ Reason ______________________ Referred by________________

Parent's email address __________________________ Would you like reminders for future appointments? Yes ❑ No ❑

General Health History

Typical sleep patterns (day and night)____

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? _____________________

Nutritional History

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? ____________________

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

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 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# ______________________________________