

## Pediatric Health History Form

Patient Name: \_\_\_\_\_  
Name of Parents/ Guardians \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell \_\_\_\_\_  
Email Address \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Sex M / F Weight \_\_\_\_\_ Height \_\_\_\_\_ Number of siblings \_\_\_\_\_  
Who referred you to us? \_\_\_\_\_  
Reason for seeking care: \_\_\_\_\_  
Other Doctors seen for this conditions Y/ N Specialty: \_\_\_\_\_  
Prior treatment and outcome: \_\_\_\_\_  
Other Health Problems: \_\_\_\_\_  
Surgery: \_\_\_\_\_

**Symptoms:** Please check any current or past problems your child has on the list below:

<input type="checkbox"/> Dizziness	<input type="checkbox"/> Allergies	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Broken Bones
<input type="checkbox"/> ADHD	<input type="checkbox"/> Runny Nose	<input type="checkbox"/> Poor Appetite	<input type="checkbox"/> Sprains/Strains
<input type="checkbox"/> Backaches	<input type="checkbox"/> Itchy Eyes	<input type="checkbox"/> Hyperactivity	<input type="checkbox"/> Hernias
<input type="checkbox"/> Heart Condition	<input type="checkbox"/> Rashes	<input type="checkbox"/> Rashes	<input type="checkbox"/> Neck pain
<input type="checkbox"/> Chronic Earaches	<input type="checkbox"/> Unusal Moles	<input type="checkbox"/> Poor Memory	<input type="checkbox"/> Arm/Elbow pain
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Neuritis	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Leg/hip pain
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Digestive problem	<input type="checkbox"/> Nightmares	<input type="checkbox"/> Knee/Foot Pain
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Sinus Trouble	<input type="checkbox"/> Bed Wetting	<input type="checkbox"/> Growing Pains
<input type="checkbox"/> Fever/Chills	<input type="checkbox"/> Cough/Wheeze	<input type="checkbox"/> Pain Urinating	<input type="checkbox"/> Joint Pain
<input type="checkbox"/> Frequent Colds	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Convulsions	<input type="checkbox"/> Paralysis
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Constipation	<input type="checkbox"/> Muscle Pain	<input type="checkbox"/> Blood Disorders
<input type="checkbox"/> Headaches	<input type="checkbox"/> Anemia	<input type="checkbox"/> Fainting	<input type="checkbox"/> Stomach Aches
<input type="checkbox"/> Asthma	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Other
<input type="checkbox"/> Tumors Benign/malignant			

### Health History:

Name of Pediatrician: \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_  
Reason for visit: \_\_\_\_\_  
Medications and conditions being treated: \_\_\_\_\_  
Has your child ever taken antibiotics Y/N condition treated: \_\_\_\_\_  
Has your child been injured participating in contact sports Y/N  
If yes describe the injury: \_\_\_\_\_  
Has your child ever been involved in a car accident? Y/N Date of injury: \_\_\_\_\_  
Has your child ever fallen head first from (Changing table, Bed, Stairs..) Y/N  
Other Traumas \_\_\_\_\_  
Menarche Y/N age: \_\_\_\_\_

**Prenatal History:**

Location of Birth: \_\_\_\_\_  
Complications during pregnancy: Y/N List: \_\_\_\_\_  
Ultrasounds during pregnancy Y?N Number: \_\_\_\_\_  
Medications during pregnancy/ delivery: Y/N List: \_\_\_\_\_  
Cigarette/Alcohol during pregnancy Y/N \_\_\_\_\_  
Birth interventions: Forceps, Vacuum, Caesarian, briefly explain reason for intervention:  
\_\_\_\_\_  
Complication's during delivery: \_\_\_\_\_  
Genetic disorders/ disabilities Y/N \_\_\_\_\_  
Birth Weight \_\_\_\_\_ Birth length \_\_\_\_\_ APCAR scores 1min \_\_\_\_\_ 5min \_\_\_\_\_

**Feeding History:**

Breast fed Y/N How long? \_\_\_\_\_ Formula fed Y/N How Long? \_\_\_\_\_  
Type: \_\_\_\_\_ Introduced to solids at \_\_\_\_\_ months Cow's mik at \_\_\_\_\_ months  
Food/ juice allergies or intolerances Y/N List \_\_\_\_\_

**Developmental History:**

Sleep (hrs per night) \_\_\_\_\_ Naps (number and Lengths) \_\_\_\_\_ Problems  
Sleeping Y/N \_\_\_\_\_  
At what age was your child able to: Crawl \_\_\_\_\_ Sit alone \_\_\_\_\_ Stand alone \_\_\_\_\_  
Walk alone \_\_\_\_\_ Say Words \_\_\_\_\_

**Childhood Illnesses:**

Check all that apply  
\_\_\_\_ Chicken pox, Age \_\_\_\_      \_\_\_\_ Mumps, Age \_\_\_\_      \_\_\_\_ Rubella, Age \_\_\_\_  
\_\_\_\_ Whooping Cough, Age \_\_\_\_      \_\_\_\_ Measles, Age \_\_\_\_      \_\_\_\_ Meningitis, Age \_\_\_\_  
\_\_\_\_ Tuberculosis, Age \_\_\_\_      \_\_\_\_ Other \_\_\_\_\_

**Vaccination History**

0 HBV/Hep (Hepatitis B) Age \_\_\_\_ 0 MMR (Measles, Mumps, Rubella) Age \_\_\_\_  
0 DPT (Diphtheria, Tetanus, Pertussis) Age \_\_\_\_ 0 Varicella (chicken Pox) Age \_\_\_\_  
0 HbCV/ Hib (h. influenzae type b conjugate) Age \_\_\_\_ 0 PCV (pneumococcal) Age \_\_\_\_  
0 OPV (oral polio vaccine) or IPV (inactivated Poliovirus) Age \_\_\_\_  
Adverse Reactions to any Vaccine Y/N List: \_\_\_\_\_

I certify that the information that I have supplied is correct and accurate to the best of my knowledge.

Signed \_\_\_\_\_ Date \_\_\_\_\_

## **Informed Consent & Office Policies**

Our commitment here at the Los Gatos Chiropractic and Wellness Center is to serve our patients with professionalism and caring, being sure at all times to protect the privacy and security of all Protected Health Information.

During the course of serving your interest it may be necessary to share information with other Health care Providers or Associates for the purpose of ordering laboratory analysis, payment, scheduling of your appointment or in the instance of a second opinion. If any other uses or disclosures other than the ones listed above are needed, information will be released with the written authorization of the individual, as provided for by law.

Please be aware Health and Safety Code section 109250 et seq., specifically prohibits the use of any unconventional remedy in the diagnosis, treatment, alleviation or cure of cancer. If you have been diagnosed with cancer we will be unable to treat you for this diagnosis.

We do not accept insurance. We ask that you know your insurance coverage prior to visiting us. All payment is expected at the time of service. Debit cards, master card, visa, cash and check are acceptable forms of payment.

Please be advised that if you cannot keep your scheduled procedure or appointment for any reason, we request that you cancel the appointment with at least 24 hours prior. Failure to cancel within that time frame or no showing for the appointment will cost a fee of \$50.

Thank you for your cooperation. We look forward to assisting you on your path to wellness.

Sincerely,

Drs. Kate Fox and Jessie Young

I have read and understand this form.

Signed: \_\_\_\_\_

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

## INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

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I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the Doctor of Chiropractic named below and/or other licensed Doctor of Chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the Doctor of Chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the Doctor of Chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to, fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and wish to rely on the doctor to exercise judgment during the course of the procedure which to doctor feels at the time, based upon the facts then known, is in my best interests.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

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To be completed by patient's representative, if necessary, e.g., if patient is a minor or physically or legally incapacitated:

\_\_\_\_\_  
Print Name of Patient

\_\_\_\_\_  
Print Name of Patient's Parent/Guardian/Representative

\_\_\_\_\_  
Signature of Patient's Parent/Guardian/Representative

As: \_\_\_\_\_  
Relationship or Authority of Patient's Representative

\_\_\_\_\_  
Date Signed

Name(s) of doctor(s) treating this patient:

Drs. Kate Fox and Jessie Young