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BALANCE FAMILY CHIROPRACTIC PEDIATRIC HEALTH HISTORY FORM

Childs Name: _____ Age: _____ Birth Date: _____ Sex: M or F

Name of Parent(s)/Guardian: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Work Phone: _____

Cell Phone: _____ E-mail Address: _____

How did you hear about our office?

Reason for Visit: Wellness Check-Up _____ Health Concern _____

Please explain if health concern:

Have you seen other doctors for this condition? Yes or No Who? _____

Type of Treatment: _____ Results: _____

Other Health Problems? _____

Check any of the following that your *CHILD* has suffered from during the past 6 months:

<input type="checkbox"/> Ear Infections	<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Seizures	<input type="checkbox"/> Colic
<input type="checkbox"/> Asthma	<input type="checkbox"/> Bed Wetting	<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Allergies
<input type="checkbox"/> Headaches	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Recurrent Fevers	
<input type="checkbox"/> Car Accident	<input type="checkbox"/> Neck/Back Pain	<input type="checkbox"/> Temper Tantrums	
<input type="checkbox"/> Digestive Problems	<input type="checkbox"/> Chronic Cold/Sinus		
<input type="checkbox"/> Other _____			

Has any other family member suffered from these symptoms? _____ Yes _____ No

Previous Chiropractor? _____

Date of Last Visit: _____ Reason: _____

Name of Pediatrician: _____

Date of Last Visit: _____ Reason: _____

Number of doses of antibiotics your child has taken:

During the past 6 months: _____ Total during his/her lifetime: _____

List of Antibiotics: _____

Vaccination History: _____

Any adverse reactions to vaccinations? _____

Prenatal History:

Name of Obstetrician/Midwife: _____

Complications during pregnancy? No Yes - List: _____

Ultrasounds during pregnancy? No Yes - Number: _____

Medications during pregnancy/delivery? No Yes - List: _____

Cigarette/Alcohol Use during pregnancy: No Yes

Location of Birth: Hospital Home Birthing Center

Birth Intervention: Forceps Vacuum Extraction

Caesarian Section - Emergency or Planned? _____

Complication during delivery: No Yes - List: _____

Genetic Disorder or Disabilities: No Yes - List: _____

Birth Weight: _____ pounds _____ ounces

Birth Length _____ inches APGAR Scores _____

Feeding History:

Breast Fed: No Yes - How Long: _____

Formula Fed: No Yes - How Long: _____ Type: _____

Introduced solids at: _____ months Cow's Milk at: _____ months

Food/Juice Allergies or Intolerances? No Yes

List: _____

Developmental History:

During the following times your child's spine is most vulnerable to stress and should be routinely checked by a Doctor of Chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference). At what age was your child able to:

_____ Respond to Sound _____ Respond to Visual Stimuli _____ Hold Head Up

_____ Cross Crawl _____ Sit Up _____ Stand Alone _____ Walk Alone

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e. bed, changing table, down stairs, etc...).

Was this the case with your child? No Yes

Is/was your child involved in any high impact or contact sports? ____ No ____ Yes
(i.e. football, soccer, gymnastics, baseball, basketball, cheerleading, martial arts, etc...)

Sport(s): _____

Has your child ever been involved in a car accident? ____ No ____ Yes

List: _____

Has your child ever been seen on an emergency basis? ____ No ____ Yes

List: _____

Other Traumas not listed above? ____ No ____ Yes - List: _____

Prior Surgery? ____ No ____ Yes - List: _____

Menarche? ____ No ____ Yes - Age: _____

Childhood Diseases:

Chicken Pox: N/Y - Age: _____

Mumps: N/Y - Age: _____

Rubella: N/Y - Age: _____

Rubeola/Measles: N/Y - Age: _____

Whooping Cough: N/Y - Age: _____

Other: N/Y - Age: _____

Upon completion of your child's first visit, you will receive a Chiropractic Report to discuss the different types of Active Life Plans that are available to you. Chiropractic Active Life Plans are designed to help get you feeling better quickly and to help you and your family be as healthy as possible. Please review the explanations of the Chiropractic Active Life Plans prior to your Chiropractic Report appointment so you can choose the level of participation that supports you and your child in reaching all of your health goals.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me or my child are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate, any fees for professional services rendered me will be immediately due and payable.

However, the patient or responsible party remains liable for any amount not paid by insurance, if any, within 30 days of our request for payment. In the event that payment is not timely made, and we must place the account for collections, you agree to pay all of our reasonable costs and expenses, including attorney fees, related to the collection of any sums due. A finance charge of 1.5% per month (Annual Percentage Rate 18.0%) will be added to the account, but the finance charge will not begin to accrue until thirty days after our request for payment.

I hereby authorize the doctor to treat my child's condition, as she deems appropriate. It is understood and agreed the amount paid for the doctor, for x-rays, is for examination only and the x-ray negatives will remain property of this office, being on file where they may be seen at any time while a patient of this office. The patient's parent or guardian also agrees that he/she is responsible for payment of all bills incurred at this office.

AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize this office and its Doctors to administer care for my son/daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Name of Insurance Company: _____ Policy #: _____

Signed: _____ Date: _____

Witnessed: _____ Date: _____