PARAGON WELLNESS CENTER

RECLAIM YOUR HEALTH. REVIVE YOUR LIFE.

Confidential Pediatric History Form

It is our pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To better serve you, please complete the following information. We look forward to working with you! Thank You!

Date: ________________________________ Referred By: ____

Child's Name: ____ Phone Number: ________________________

Do you have other immediate household family members who are patients here? Y N

If yes, please list them ____

Address: ____________________________________ City: __________________ State: _____ Zip: ___________

Sex: M F Weight: _________ Height: ________ Birth Date: _______________

Name of Parents/Guardians: ___________________________________ Phone Number: ______________________

Purpose for Contacting Us? ____

Other Doctors seen for this condition: Y N If yes, please list doctor's name and prior treatments: ___________

____

Check any of the following conditions your child has suffered from during the past six months:

- ○ Ear infections
- ○ Asthma/Allergies
- ○ Colic
- ○ Scoliosis
- ○ Digestive problems
- ○ Bed Wetting
- ○ Seizures
- ○ ADHD
- ○ Auto Accident
- ○ Chronic Colds
- ○ Recurring Fevers
- ○ Temper Tantrums
- ○ Headaches
- ○ Growing/Back pains
- ○ Other: ________________ ______________________

Family History: ____

Previous Chiropractor: ______________________________ Date of Last Visit: _________________ Reason: ___________________

Were you satisfied? Y N Why? ____

Previous / Current Pediatrician: ______________________________ Date of Last Visit: ______________ Reason: ___________________

Number of doses of antibiotics your child has taken:

a) During the past six months: ____

b) Total during his/her life: ____

Number of doses of other prescription medications your child has taken:

c) During the past six months:____

d) Total during his/her life:____

Vaccination History: ____

Feeding History

Breast Fed:Y N If yes, how long?_________________ Formula:Y N If yes, how long:________________________

Introduced to solids at _____ months. Cow's milk at _____ months. Food/juice allergies or tolerances:Y N If Yes, Please List:

If Yes, please list:____________________________ Other allergies or tolerances: Y N If Yes, please list:____________________

Number of Hours Sleeping per Night: ___________ Quality of Sleep: Good Fair Poor

Prenatal History:

Name of obstetrician/midwife: ________________________________ Pediatrician / Family MD:

__________________________________ Birth intervention: Forceps________ Vacuum Extraction: _______ Caesarian Section: _______

Emergency or Planned?: ________________ Ultrasounds during pregnancy? Y N If yes, how many:_______________________

Medications during pregnancy/delivery?Y N If Yes, please list them:____

Cigarette/alcohol use during pregnancy?Y N How much and how often? ____

Childhood Diseases:

Chicken Pox: Y N Age:_____ Rubeola: Y N Age:_____ Whooping Cough: Y N Age:_____

Rubella: Y N Age:____ Other: ________________________

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. a bed, changing table, down stairs, etc.). Was this the case with your child? Y N – If yes, please explain___________________

____

____

Is/has your child been involved in any high impact or contact sports (i.e. soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.). Y N If Yes, Please list: ____

____

Has your child ever been involved in a car accident? Y N If yes, please explain:_____________________________________

____

WE ARE HERE TO SERVE YOU, AND ENCOURAGE BOTH YOU AND YOUR CHILD TO ASK QUESTIONS. YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR RESULTS.

I hereby authorize Dane Ericson, DC - Affiliate of The Wellness Way to administer care to 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. Please send completed form to **info@paragondrs.com**

Signed: ____ Relationship to Patient: ________________________ Date: _________________________

Acknowledgments

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial.

I instruct the chiropractor to deliver the care that, in his or her professional judgment, can best help me in the restoration of my health. I also understand that the chiropractic care offered in the practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure and disease or entity.

Initials: ______

I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

Initials: ______

I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY) ____________

Initials: ______

I grant permission to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.

Initials: ______

I acknowledge that any insurance I may have is an agreement between the center and me and that I am responsible for the payment of any covered or non-covered services I receive.

Initials: ______

To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concerns.

Initials ______