Today's Date_________________

PEDIATRIC FORM

Please fill out this form as completely and accurately as possible. All information requested below is necessary for us to serve your child with the best possible care.

ABOUT THE CHILD

Name____ Birth Date______/______/_______
Age___________ Gender □M □F Height_______________ Weight________________
Address______________________________City_________________State______Zip ___________
Parent/Legal Guardian____________________________________ Phone (___) ________________
Occupation___________________________________Employer____________________________
SS# (opt'l) _____-____-_________Email____

Whom may we thank for referring you to our office?
____

PURPOSE OF VISIT

Describe the purpose of this visit:____
____
____

Is the purpose of this visit related to:
□ sports □ auto □ fall □ home injury □ chronic discomfort
□ other ________________ Explain: ____

When did this condition begin? ____
Has this condition:
□ become worse □ stayed constant □ comes and goes

Does this condition interfere with:
□ sleep □ daily routine □ other activities
Explain:
____

Has this condition ever occurred before? □Y □N
Explain:
____

Have your seen other doctors for this condition? □Y □N
Doctor's Name and Phone Number(s):
____
Treatment:
____
Results:
____

MOTHER'S PREGNANCY & LABOR

During pregnancy, did the mother:
…..take any medication? □Y □N If yes, explain:____
…..smoke or consume alcohol? □Y □N
…..experience any illness? □Y □N If yes, explain:_______________________________________
Approximately how long did labor last?________hours
Was labor chemically induced? □Y □N
Was labor doctor assisted? □Y □N
Was a C-section performed? □Y □N
Were forceps or vacuum extraction used? □Y □N
Did the delivery doctor pull or twist the baby during delivery? □Y □N □ unsure
Was the delivery premature? □Y □N
If yes, at __________weeks, weight_____lbs____oz
Check any of the following if the child experienced it immediately after birth:
□ jaundice □ respiratory problems
□ feeding problems □ displaced or broken joints
□ other condition(s)
Explain:
____

CHILD'S HEALTH HISTORY

Please check each of the following the child has now or has had in the past. While they may seem unrelated to the purpose of the visit, they can affect the overall diagnosis and course of care.

□ vision problems
□ pink eye
□ headaches
□ ear problems
□ sleeping disorders
□ tubes in the ears
□ irritability
□ attention problems
□ skin problems
□ allergies
□ colic
□ breathing problems
□ digestive problems
□ asthma
□ hyperactivity
□ constipation
□ bed wetting
□ frequent colds
□ other_____________________

VACCINATIONS

Please check which of the following statements best describes your child and vaccinations:
□I have chosen not to vaccinate my child.
□My child is partially vaccinated.
□My child has received all vaccinations on the medical vaccine schedule
□Any noted side effects or reactions? □Y □N
Explain:____
____

CHILD'S CURRENT HEALTH STATUS

Is your child accident prone? □Y □N □ unsure

Has your child ever:

…..been hospitalized? □Y □N

…..had a severe fall? □Y □N

…..been in a car accident? □Y □N

Has your child ever taken antibiotics? □Y □N

If yes, explain for what condition(s) and for how long:

____

____

Does your child have difficulty interacting with schoolmates or friends? □Y □N

Have you or anyone else noticed that your child is nervous, twitches, shakes, or exhibits a rocking behavior? □Y □N

What improvements (if any) in your child's health or behavior would you like to accomplish?

____

____

GOALS FOR MY CHILD'S CARE

Children are seen by chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of the pain, and others for corrections of malfunctions in their bodies. Dr. Gillen or Dr. Livingston will weigh your needs and desires when recommending your child's chiropractic care plan. Please check the type of care desired so that we may be guided by your wishes whenever possible.

□ RELIEF CARE –Symptomatic relief of pain or discomfort

□ CORRECTIVE CARE –Correcting and relieving the cause of the problem as well as the symptoms.

□ COMPREHENSIVE CARE –Bring whatever is malfunctioning in the body to the highest state of health possible with chiropractic care.

□ I wish the doctor to select the type of care appropriate for my child.

AUTHORIZATION TO CARE FOR A MINOR CHILD

I hereby authorize Dr. Kali Gillen/ Dr. Stacy Livingston and Pinnacle Chiropractic, PLLC to work with my child (name) ___________________________________ through the use of adjustments and procedures as Dr. Gillen or Dr. Livingston deems appropriate. If at any time any procedure makes me feel uncomfortable, I have the responsibility to notify Dr. Gillen or Dr. Livingston immediately so any concerns can be addressed. It is important that both doctor and patient are working together towards the same goals. I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. Dr. Gillen or Dr. Livingston will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and policy holder. I understand that Pinnacle Chiropractic, PLLC will prepare any necessary reports and forms to assist me in collecting from the insurance company.

______________________________ ______________________________

Patient's Name (print) Parent/Legal Guardian's Name (print)

______________________________ ______________________________

Authorizing Care Date (mm/dd/yy) Parent/Guardian's Signature

Thank you for choosing Pinnacle Chiropractic, PLLC.
We look forward to helping you.