CONFIDENTIAL PEDIATRIC HEALTH HISTORY

Please PRINT clearly.

KOSTERMAN CHIROPRACTIC

Today's Date: _____

PATIENT INFORMATION

Name: (Last, First, MI) _____ **Preferred Name:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Birth Date: _____ **Age:** _____ **Child's Gender: M / F** **Email:** _____

Mother: _____ **Father:** _____ **Phone:** _____

CMS requires providers to report both race and ethnicity

Ethnicity: Not Hispanic or Latino / Hispanic or Latino / Other / Decline to Answer

Race: Asian /Black or African American /American Indian or Alaska Native /White /Hawaiian or Pacific Islander / Other/Decline to Answer

FINANCIAL INFORMATION -- *Please allow our staff to photocopy your insurance card.*

Insurance **Self Pay (Cash)** **Personal Injury/Auto** **Other (please explain)** _____

Insurance Company: _____ Name of Insured: _____ Relation to Insured: _____

INFANTS, NEWBORNS and YOUNG CHILDREN – HEALTH HISTORY

Describe Current Complaints for seeking care (include when and how): _____

_____

Grade Severity/Intensity: None / Mild / Moderate / Severe / Very Severe **Frequency of Complaint:** Off and On / Constant

What relieves the complaint: _____ **What makes it worse:** _____

What daily activities are being affected by this complaint: _____

Has the child received any prior treatment for this condition?

DC / MD / PT / Massage / ER / Other: _____ Where? _____

Surgery? *(Describe)* _____

Medications? OTC / Prescriptions *(Describe)* _____

Diagnostic testing? X-rays / MRI / CT / Other: _____ When and Where? _____

❑ Acupuncture ❑ Massage ❑ Other: _____

PRE and POSTNATAL HISTORY

Birth Weight: _____ **Birth Length:** _____ **Full Term?** ❑ No ❑ Yes *(Describe):* _____

Complications during pregnancy? ❑No ❑ Yes *(Describe):* _____

Medications during pregnancy or delivery? ❑ No ❑ Yes *(List):* _____

Cigarette/Alcohol/Drugs during pregnancy? ❑No ❑ Yes *(List):* _____

Birth Interventions? ❑ No ❑ Forceps ❑ Vacuum ❑ Caesarian ❑Other _____

FEEDING HISTORY

Breast fed? ❑No ❑ Yes *(How Long?)* _____ **Formula fed?** ❑ No ❑ Yes *(How Long?)* _____

Introduced to cereal at _____ months old. **Introduced to solids at ____ months old.**

Food/Juice allergies or intolerances? ❑No ❑Yes *(Describe):* _____

DEVELOPMENTAL HISTORY

Sleep *(Hours per Night?)* _____ **Problems Sleeping?** *(Describe)* _____

Rolling Over ❑ **Sitting ❑** **Crawling ❑** **Walking ❑**

Current Level of Education: _____ **N/A**

HAS YOUR CHILD EVER SUFFERED FROM: (*Check all that apply)*

Pediatric

- ❑ ADHD
- ❑ Allergies/Asthma
- ❑ Autism
- ❑ Back/Neck Pain
- ❑ Bed Wetting
- ❑ Behavioral issues
- ❑ Chronic Earaches
- ❑ Colic
- ❑ Constipation
- ❑ Growing Pains
- ❑ Nightmares
- ❑ Reflux
- ❑ *None in this Category*
- ❑ Other: _____

Childhood Diseases

- ❑ Chicken Pox: Age____
- ❑ Measles: Age____
- ❑ Meningitis: Age____
- ❑ Mumps: Age____
- ❑ Rubella: Age____
- ❑ Tuberculosis: Age____
- ❑ Whooping Cough: Age____
- ❑ Other: _____ Age____
- ❑ *None in this Category*

Has your child been vaccinated?

❑ No ❑ Yes

(Any Adverse Reactions? – Describe:)

_____

Current Medications:_____ Past Medications:_____

Surgeries: ❑ Ear Tubes left / right / both ❑ Tonsils / Adenoids ❑ Other:_____

Allergies to Medications:_____ Major Hospitalizations (other than birth)_____

Major Injuries/Traumas:_____ Family Health History:_____

CONSENT FOR TREATMENT OF MINOR

I hereby authorize Dr. Jaffe or whomever he may designate as assistants to administer examinations and chiropractic care as deemed necessary to:_____(minor patient's name).

Printed Name Parent/Guardian:_____ Witness:_____ Date: _____

Signature Parent/Guardian:_____Date:_____