Whom May We Thank for referring you to our office? _____

Thrive CHIROPRACTIC PEDIATRIC HISTORY FORM

PATIENT DEMOGRAPHICS

Childs Name_____ Today's Date _____/_____/____

Date of Birth _____/_____/_____ Birth Height: _____ Birth Weight: _____ Current Height: _____

Current Weight: _____ Age: _____ Address _____

City _____ State _____ Zip _____ Phone (cell) _____ text or call

Mothers Name: _____Mother's Cell _____ text or call

DOB____/____/____ Mother's Social Security # _____-_____-_____

Fathers name: _____Father's cell_____ text or call

DOB ____/____/____ ☐ Father's Social Security # _____-_____-_____

☐ Other *(please explain):*

_____

Pediatrician/Family MD _____City & State _____

Last Visit: ____/____/____ Reason for visit:_____

Who is responsible for this bill? _____

CHILD'S CURRENT PROBLEM:

Purpose of this visit: _____Wellness Check-up _____Injury or Accident _____Other

Please explain: _____

If your child is experiencing ***Pain/Discomfort please identify where and for how long*** _____

_____

1. **When did the** Problem first begin? Date ____/____/____ _____Unknown _____Gradual ____Sudden
2. **Ever had** this problem **before**? No_____ Yes_____ If yes when? _____
3. Any **bowel or bladder** problems since this problem began?: If yes,

   (Describe):_____
4. Have you seen any **other doctors** for this problem? No Yes If yes who? _____
5. How long ago? _____ Days _____ Weeks _____ Months _____ Years
6. What were the results of past treatment? _____

7. How is this problem **NOW:** ☐ Rapidly Improving ☐ Improving Slowly ☐ About the Same

☐ Gradually ☐ Worsening ☐ On & Off

8. Please list any **medication taken** for this problem: _____

9. Has your child ever sustained an injury playing organized sports? _____ If yes; please explain

_____

_____

10. Has your child ever sustained an injury in an auto accident? _____ if yes, please explain

_____

HAS YOUR CHILD EVER SUFFERED FROM: *mark "X" for all that applies!*

□ Headaches	□ Orthopedic Problems	□ Digestive Disorders	□ Behavioral Problems
□ Dizziness	□ Neck Problems	□ Poor Appetite	□ ADD/ADHD
□ Fainting	□ Arm Problems	□ Stomach Aches	□ Ruptures/Hernia
□ Seizures/Convulsions	□ Leg Problems	□ Reflux	□ Muscle Pain
□ Heart Trouble	□ Joint Problems	□ Constipation	□ Growing Pains
□ Chronic Earaches	□ Backaches	□ Diarrhea	□ Allergies
□ Sinus Trouble	□ Poor Posture	□ Hypertension	□ Asthma
□ Scoliosis	□ Anemia	□ Colds/Flu	□ Walking Trouble
□ Bed Wetting	□ Colic	□ Broken Bones	□ Sleeping Problems
□ Fall in baby walker	□ Fall from bed or couch	□ Fall from crib	□ Fall off swing
□ Fall off bicycle	□ Fall from high chair	□ Fall off slide	□ Fall down stairs □Fall from changing table
	□ Fall off monkey bars	□ Fall off skateboard/skates	

□ Other: _____

I understand that I am directly and fully responsible to Thrive Chiropractic for all fees associated with chiropractic care my child receives.

The risks associated with exposure to ionization and spinal adjustments have been explained to me to my complete satisfaction, and I have conveyed my understanding of these risks to the doctor. After careful consideration I do hereby request and authorize imaging studies and chiropractic adjustments for the benefit of my minor child for whom I have the legal right to select and authorize health care services on behalf of.

☐ Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other guardian is not required. If my authority to so select and authorize this care should change in any way, I will immediately notify this office.

_____ _____

Parent or Legal Guardian's Signature Date

_____ _____

Doctors Signature Date

Patient Name _____ Todays Date _____

Insurance Information (Must be completed before services are rendered)

Name of **Primary** Insurance Carrier: _____

Name of Insured (**if other than the patient**): _____

Insured DOB (**if other than the patient**):_____

Insured Social Security #: _____/_____/_____

Name of **Secondary** Insurance Carrier: _____

Name of Insured (***if other than the patient***): _____

Insured DOB (***if other than the patient***):_____

Insured Social Security #: _____/_____/_____

Insurance Policies and Fee Schedules

- **Consultation** – includes practice member history. This service is complimentary.
- **Examination** (new patient or established patient) – includes one or more of the following: thermography, surface, electromyography, range of motion and/or static palpation, leg check. $50-$75
- **Chiropractic Adjustment** – the actual re-alignment of the vertebra done by hand. Often a sound will be heard, but if there is no auditory result it does not mean that the adjustment has not taken place. $40-$60
- **X-rays** – specific x-ray views taken of your spine to determine a misalignment/subluxation of your vertebrae. These can also be used to indicate progress after a period of care.

Patient Signature: _____ Date _____

Witness Signature: _____ Date _____