HATBORO FAMILY WELLNESS CHILDREN'S HEALTH HISTORY FORM

Please fill out this form as completely and accurately as possible. **Fax** (215) 394-5428 **OR scan and email** (drtara@hatborowellness.com) **your forms** to the office and **bring your originals** with you to your first visit.

Today's Date______________________

ABOUT YOUR CHILD

Name ____ Age ______ Date of Birth ______________________________

Gender ❑ M ❑ F Height _____________________ Weight ____________________________

Home Address ____________________________________City __________________ State ______ Zip ____________

Names and Ages of Siblings____

Parent A	Parent B
Name ____	Name ____
Home phone (________) _________________________	Home phone (________) _________________________
Cell phone (________) ___________________________	Cell phone (________) ___________________________
Employer _______________________________________	Employer _______________________________________
Occupation _____________________________________	Occupation _____________________________________
E-mail ____	E-mail ____

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

REASON FOR SEEKING CHIROPRACTIC CARE

What concern do you feel Hatboro Family Wellness can address for your child? _________________________________

____

Rate your level of concern / worry (0=none and 10=extremely concerned): ______ Is this becoming worse? ❑ No ❑ Yes

Related to: ❑ Sports ❑ Auto ❑ Fall ❑ Chronic ❑ Home Injury ❑ Other ___________________________

Please describe how these concerns are affecting your child's quality of life. ____________________________________

____

Aspects of life that are affected

❑ School
❑ Playing
❑ Communication
❑ Exercise/Sports
❑ Sleep
❑ Eating
❑ Walking
❑ Attention/Focus
❑ Daily Routine

EXPECTATIONS OF CARE

I would like my child to experience the following benefits from Chiropractic Care:

Check all that apply

❑ Symptomatic relief of complaint
❑ Correction of the cause of the problem as well as relief of symptoms
❑ Prevention of future problems
❑ Healthier spine and nerve system
❑ Optimal physical health and nerve system function
❑ OTHER____

HEALTH, WELLNESS AND CHIROPRACTIC CARE

The primary system in the body which coordinates health is the NERVE SYSTEM.
The vertebrae (bones of the spinal column) surround and protect the delicate NERVE SYSTEM.
Injury to the SPINE and NERVE SYSTEM is a condition called VERTEBRAL SUBLUXATION.
VERTEBRAL SUBLUXATION results in nerve malfunction due to vertebral/spinal misalignment.

Vertebral Subluxations can have Physical, Emotional and Chemical causes and effects.

The information below will help us to see the types of **PHYSICAL, EMOTIONAL & CHEMICAL** stresses your child has been subjected to, how they may relate to his/her present spinal, nerve and health status and whether they may have caused **Vertebral Subluxations** to occur.

PREGNANCY & BIRTH

Science now indicates that the mother's emotions and experiences during pregnancy can affect their baby.

The pregnancy was ❑ Welcomed ❑ Planned ❑ Unexpected ❑ Other ____________________________________

How would you describe the pregnancy: ❑ Enjoyable ❑ Stressful ❑ Sick often ❑ Fear / Worry ❑ Difficult

During pregnancy, did the mother:

❑ Experience any significant illnesses, emotional stress, difficulties, or trauma? ________________________________

____

❑ Take any drugs/medications? ____

❑ Smoke or consume alcohol ____

Birth location ❑ Home birth ❑ Hospital birth ❑ Birth Center

Child's gestational age at birth __________ weeks Birth Weight _____lbs ____oz Birth Length _______ inches

Describe labor/delivery ❑ Vaginal ❑ C-Section ❑ Spontaneous ❑ Induced ❑ Slow ❑ Quick ❑ Water birth

Approximately how long did labor last? __________ hours How many hours of pushing _________________

The birth process can be traumatic to a baby's spine and cause interference to the nervous system. Please check which of the following were used during labor and birth.

❑ Epidural ❑ Forceps ❑ Vacuum Extraction ❑ Medication ____
❑ Pitocin ❑ Episiotomy ❑ Assistance / pulling on neck or body ❑ None

Was the child ever breech, transverse or malpositioned during the pregnancy? ❑ No ❑ Yes

Were there any complications/concerns during labor and delivery? ❑ No ❑ Yes If Yes, please explain ____________

____

Please check all that apply to the baby's status immediately after birth:

❑ Jaundice ❑ Respiratory problems ❑Other conditions ________________________________
❑ Feeding problem ❑ Displaced joints / hip problems ❑ None

APGAR Score _________________________

CHEMICAL STRESS

Chemical stresses can occur when a substance that is toxic to the body is breathed, injected, taken by mouth, or comes into contact with the skin. The following will reveal exposures your child may have experienced.

Was or is your child breastfed? ❑ No ❑ Yes For how long? ____

Did your child ever favor feeding on one side over the other? ❑ No ❑ Yes ❑ Right ❑ Left

Formula fed? ❑ No ❑ Yes Starting when? ____________________ Type ______________________________

Have you chosen to vaccinate your child? ❑ No ❑ Yes ❑ Alternate schedule ❑ Delayed

Please describe any and all reactions to vaccine(s)____

Please check all that apply and give any necessary details:

❑ Child is exposed to second hand smoke.

❑ Has taken antibiotics. Explain ____

❑ Currently taking medication. Explain ____

❑ Currently taking supplements. Explain ____

❑ Has allergies. Explain ____

❑ Additional treatment(s). Explain ____

PHYSICAL STRESS: INFANCY & CHILDHOOD

Your child's preferred sleeping: ❑ Front ❑ Back ❑ Side

If applicable: What age did your child: Sit alone: _____months Crawl: _____months Walk: _____months

Please check all that apply to your child and give any necessary details:

❑ Has had an injury resulting in bruising, stitches, cuts ____

❑ Has had a fall from couch, bed, change table, etc. ____

❑ Uncoordinated/Accident prone ____

❑ Has been hospitalized ____

❑ Had a severe trauma ____

❑ Been in an automobile accident ____

❑ Has fractured a bone or dislocated a joint ____

❑ Has had surgery ____

What physical activities does your child participate in? ____

EMOTIONAL STRESS

It is difficult to separate the emotional stress in our life from the physical response that often occurs. Please indicate if your child **has ever or is currently** experiencing any of the emotional stresses below:

❑ Loss of a loved one ❑ Bullying ❑ New Home ❑ Academic pressure ❑ None known
❑ Lifestyle change ❑ Parental divorce ❑ Loss of a pet ❑ New sibling

Does your child have difficulty interacting with peers? ❑ No ❑ Yes Any behavioral problems? ❑ No ❑ Yes

Any difficulty **sleeping**? ❑ No ❑ Yes Average hours of sleep in 24 hours? ____________

Average TV or video game time: ______ hours per weekday ______ hours per Saturday or Sunday ❑ N/A

REVIEW OF SYSTEMS

Often seemingly unrelated symptoms can manifest as other health concerns. Please **indicate if your child has EVER had** any of the following. **Circle current and/or ☒ check past conditions. (Indicate both if applicable).**

□ headaches	□ asthma	□ weight loss	□ vision problems / glasses
□ dizziness	□ sinus congestion	□ abnormal weight gain	□ ears ringing
□ irritability	□ frequent colds	□ heartburn	□ weakness
□ fatigue	□ sore throats	□ heart palpitations	□ upper back pain
□ depression	□ ear pain/infections	□ chest pressure	□ lower back pain
□ loss of balance	□ fevers	□ numbness in feet	□ neck pain
□ sleeping problems	□ cold sweats	□ numbness in hand(s)	□ joint pain
□ fainting	□ bronchitis	□ numbness in leg(s)	□ reduced mobility
□ poor coordination	□ pneumonia	□ dental problems	□ muscle cramps
□ loss of taste	□ difficulty breathing	□ loss of memory	□ radiating pain
□ loss of smell	□ constipation	□ loss of concentration	□ stiffness
□ allergies	□ diarrhea	□ urinary problems	□ growing pains

HEALTH CARE PRACTITIONER HISTORY

Current Family Physician or Pediatrician: ____ Phone: __________________

Address: ____

Has your child ever received chiropractic care? ❑ No ❑ Yes Name of D.C. ___________________________________

Reason _____________________________________ How long? ________________ Date of last visit ______________

Why was care stopped? ____

Have you consulted or do you regularly consult any of the following providers for your child?

Check all that apply ❑ Naturopath ❑ Acupuncturist ❑ Homeopath ❑ Other
❑ Massage Therapist ❑ Psychotherapist ❑ Energy Healer

Reason ____

____

Name(s) of providers indicated above____

____

ADDITIONAL INFORMATION

Please list any other questions or concerns you have or anything else you want us to know about your child or family:

____

____

____

____

____

PLEASE READ AND SIGN BELOW

The information I have provided, on this case history form, is true and accurate, to the best of my knowledge.

Guardian Signature: ____

FINANCIAL AGREEMENT

I understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment for all bills incurred at this office. I also understand that payment is expected at the time of service unless arrangements are made in advance. You will be informed of any fees associated with your visit prior to services being rendered. If you are unsure of the fee, please ask.

The following information will help you to understand how insurance can be utilized in our office and the details regarding your participation in the process.

We participate with insurance as an out-of-network provider. Insurance is a contract between the insured (patient) and the insurance company irrespective of you specific needs or care recommendations. Insurance companies, such as HMO's, PPO's and others, create their own guidelines, reimbursement rates and coverage. If chiropractic services are covered, the amount and type of reimbursement varies according to the policy that has been purchased by you or your employer.

In order to determine your insurance coverage, please obtain an **Insurance Verification Form,** from our staff or website, and contact your insurance company to determine the amount and extent of coverage. **You are responsible for contacting your insurance company to determine what they need in order for them to reimburse you directly.** If you have determined that your insurance will cover chiropractic care in our office, we can provide you with a periodic statement which includes charges, services provided, and diagnosis codes**. We will offer you additional assistance in the process as needed, just ask!** The insurance company is responsible to you, as the subscriber, not to us, the provider.

I understand that I am personally responsible for direct payment to Hatboro Family Wellness for all services received regardless of my insurance company's decision to pay. If I choose to submit for potential reimbursement, I understand and agree to obtain and complete all forms necessary for potential reimbursement of services which would be directly paid to me, the patient/guardian.

Patient Name Printed: ____

Guardian Signature: ____ Date: ___________________

Thank you for choosing Hatboro Family Wellness.
We look forward to helping you.