CONFIDENTIAL PATIENT HEALTH HISTORY

Please PRINT clearly.

Today's Date: ___________________________

PATIENT INFORMATION

Name: (Last, First, MI) ____ Preferred Name: _________________________

Address: ____ City: ________________________ State: __________ Zip: ___________

Home Phone: ________________________ Mobile: ______________________________ Work: ____________________________________

Email: ____ Gender: M / F Marital Status: Married / Single / Other

Date of Birth: _____________________ Occupation: _____________________________

Spouse/Significant Other: _________________________

Referred by *(name)*: ____

☐ Family ☐ Friend ☐ Co-Worker ☐ Doctor ☐ Other: _____________________

-CMS requires providers to report both race and ethnicity-

Ethnicity: Not Hispanic or Latino / Hispanic or Latino / Other / Decline to Answer Preferred Language: ______________________

Race: Asian / Black or African American / American Indian or Alaskan Native / White (Caucasian) / Hawaiian or Pacific Islander / Other / Decline

Smoking Status: Every Day / Some Days / Former / Never

EMERGENCY CONTACT INFORMATION

Full Name: ____ Preferred Contact Number: ________________________________

Relationship: Child / Parent / Spouse / Other: ________________

Primary Care Physician: ___________________________________ Doctor's Phone: ____

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

Self-Pay (Cash) Insurance Personal Injury/Auto Other (please explain) ____________________________

PRIMARY INSURANCE: ______________________________ SECONDARY INSURANCE: ________________________

Policy Holder: ____ Policy Holder: ____

Relation to Insured: Self / Spouse / Parent / Child / Other Relation to Insured: Self / Spouse / Parent / Child / Other

CURRENT CONDITION INFORMATION *PLEASE ANSWER ALL QUESTIONS* Pediatric Patient Information:

Present Health Challenges:

For what health challenge(s) is your child here for?

____

____

When did it begin? ____

Has your child seen other health care practitioners for this? What did they recommend?

____

____

Is this dysfunction getting progressively worse? _____Yes _____No

Health History:

Symptoms: Please check any current or past problems on the list below:

____ Hates tummy time ____ Constipation ____ Asthma

____ Frequent arching backward ____ Bed Wetting ____ Chronic Earaches

____ Colic ____ Digestive Problems ____ Frequent colds

____ Muscle Pain ____ Neck Pain ____ Nightmares

____ Reflux/Spitting Up ____ Gassy ____ Difficulty Latching

____ Bloating ____ Trouble Sleeping ____ Other: ______________________

Prenatal History:

Location of Birth: _____ Home _____ Birth Center _____ Hospital

Complications during pregnancy: Yes/No List: ____

Medication during pregnancy/delivery: ____

Birth Intervention: _____ Forceps _____ Vacuum _____ Caesarian

Complications during delivery: ____

Feeding History:

If currently breast feeding does baby latch easily on both sides? _____Yes _____ No

Breast or formula fed? ____________________ How long? __________________________

Does anyone in your IMMEDIATE family have a history of (circle condition): ☐ NONE

Heart Disease If yes, who _______________ **Stroke** If yes, who _______________

Cancer If yes, who _______________ Type________________

Other Relevant Family History: ______________________________

PAST HEALTH HISTORY: (List even if it was 20 years ago…)

Injuries, Traumas or Hospitalizations: ☐ NONE ______________________________

Surgeries – Date, Type and Reason: ☐ NONE ______________________________

Breastfeeding Symptoms, Do you or your baby *CURRENTLY* experience any of these symptoms? (Check all that apply)

Baby symptoms:

- ☐ N/A
- ☐ Poor latch with breast or bottle
- ☐ Reflux Symptoms
- ☐ Spits up with most feeds
- ☐ Frequent hiccups
- ☐ Gassy
- ☐ Colic
- ☐ Clicking or smacking sounds with feeding
- ☐ Cries a lot/extra fussy
- ☐ Falls Asleep when feeding
- ☐ Poor weight gain
- ☐ Milk dribbles out of the corners of the mouth when feeding
- ☐ Choking, gulping, gasping at the breast
- ☐ Difficulty maintaining latch
- ☐ Congested nose
- ☐ "Noisy" baby when sleeping, snoring, loud breathing
- ☐ Mouth breathing/mouth opened when sleeping
- ☐ Frustrated when at the breast
- ☐ White coating of tongue
- ☐ Gagging when feeding
- ☐ Slides on and off the nipple when breastfeeding
- ☐ Biting and chewing the nipple
- ☐ Pacifier falls out
- ☐ Cranial asymmetries
- ☐ Preferred Head position when feeding

Mothers Symptoms when breastfeeding:

- ☐ N/A
- ☐ Painful Nursing (only 50% of ties will have maternal pain)
- ☐ Lipstick shaped nipple
- ☐ Cracked, creased, flattened nipple
- ☐ Bleeding and damaged nipples
- ☐ Incomplete emptying of the breast
- ☐ Low Supply
- ☐ Clogged ducts, engorgement, mastitis
- ☐ Prolonged feedings/feeding feels like a full time job
- ☐ Baby gets tired and fatigued

Is there anything else you would like the doctor to know? ______________________________

____

____

I have read the above information and certify it to be true and correct to the best of my knowledge and hereby authorize this office to provide me with chiropractic care, diagnostic testing, and/or therapeutic services, in accordance with this state's statutes. I choose to decline receipt of my clinical summary after every visit. (These summaries are often blank as a result of the nature and frequency of chiropractic care.)

Patient or Guardian Signature ______________________________ Date__________________

Doctor Signature ______________________________ Date __________________