AGAPE CHIROPRACTIC PEDIATRIC HEALTH FORM

PATIENT DEMOGRAPHICS HR#: _____

Today's Date: ____/____/____

Childs Name: _____

Date of Birth: ____/____/____ Age: _____

Birth Height: _____ Birth Weight: _____ Current Height: _____ Current Weight: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone (Home): _____

Mother's Name: _____ DOB: ____/____/____ Mother's Mobile: _____

Father's Name: _____ DOB: ____/____/____ Father's Mobile: _____

Pediatrician/ Family MD: _____ City/State: _____

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

Who is responsible for this bill? _____

Father's Social Security # : _____-_____-_____ Mother's Social Security # : _____-_____-_____

Other (please explain): _____

Prenatal History (Circle what applies)

Name of Obstetrician/ Midwife: _____

Complications during pregnancy/ delivery? Y/N Explain: _____

Medications taken during pregnancy/ delivery? Y/N List: _____

Cigarette/ Alcohol use during pregnancy? Y/N

Location of birth (circle one): Hospital Birthing Center Home

Birth Intervention (circle one): Forceps Vacuum Extraction Caesarian

Section If Caesarian Section, was it (circle one): Emergency Planned

Genetic disorders/disabilities? Y/N List:_____

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 bowl or bladder problems since this problem began?: __ No __ Yes If yes, please explain:
   _____
   _____
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 and an injury playing organized sports, Falls (bed, changing table, crib, tripped), Auto Accidents, etc.…? __ No __ Yes If yes, please explain:
   _____
   _____
   _____

HAS YOUR CHILD EVER SUFFERED FROM: Check all that apply

⇨ Headaches
⇨ Orthopedic Problems
⇨ Digestive Disorders
⇨ Behavioral Problems
⇨ Dizziness
⇨ Neck Problems
⇨ Poor Appetite
⇨ ADD/ADHA
⇨ 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
⇨ Asthma
⇨ Sinus Trouble
⇨ Poor Posture
⇨ Hypertension

⇨ Walking Trouble
⇨ Scoliosis
⇨ Anemia
⇨ Colds/Flu
⇨ Sleeping Problems
⇨ Bed Wetting
⇨ Colic

⇨ Broken Bones
⇨ Fall off Swing
⇨ Fall in Baby Walker
⇨ Fall from bed or couch
⇨ Fall from crib
⇨ Fall down stairs
⇨ Fall off bicycle

⇨ Fall from high chair
⇨ Fall off slide
⇨ Fall from changing table
⇨ Fall off monkey bars
⇨ Fall off skateboard/skates

Allergies to: _____

Other: _____

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

⇨ 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

_____ _____

Doctor's Signature Date

We love to have kid's pictures in our office! If you would allow us to have your child's picture in the office, please sign below.

For valuable consideration, I hereby irrevocably consent to and authorize the use and reproduction by Agape Chiropractic, or anyone authorized by Agape Chiropractic, of any and all photographs/videos which were taken of my child, for the purposed of promotional TV, website, social media and/or print ad whatsoever, without further compensation to me. All negatives and positives, together with the prints shall constitute the property of Agape Chiropractic, solely and completely. Any information voluntarily provided by a patient shall also be used in conjunction with the above listed information for purposes previously mentioned. Confidentially, in regards to any reported conditions, is also waived to the extent of information pertinent to the promotion material only. I authorize Agape Chiropractic to share this information via their website and their Facebook/social media including Twitter and Instagram, and for use in the office. All other unrelated patient information shall remain private and protected (according to Health Information and Privacy Act laws).

Signature:_____Date: _____

X-RAY AUTHORIZATION

AS YOUR HEALTHCARE PROVIDER, WE ARE LEGALLY RESPONSIBLE FOR YOUR CHIROPRACTIC RECORDS. WE MUST MAINTAIN A RECORD OF YOUR X-RAYS IN OUR FILES. AT YOUR REQUEST, WE WILL PROVIDE YOU WITH A COPY OF THE X-RAYS IN OUR FILES.

PLEASE NOTE: IF X-RAYS ARE NECESSARY, THEY ARE UTILIZED IN THIS OFFICE TO HELP LOCATE AND ANALYZE VERTEBRAL SUBLUXATIONS. THESE X-RAYS ARE NOT USED TO INVESTIGATE FOR MEDICAL PATHOLOGY. THE DOCTORS OF AGAPE CHIROPRACTIC DO NOT DIAGNOSE OR TREAT MEDICAL CONDITIONS; HOWEVER, IF ANY ABNORMALITIES ARE FOUND, WE WILL BRING IT TO YOUR ATTENTION SO THAT YOU CAN SEEK PROPER MEDICAL ADVICE.

CHIROPRACTIC POSTURAL XRAYS. HOWEVER, PLEASE SIGN BELOW FOR FUTURE REFERENCE.

BY SIGNING BELOW YOU ARE AGREEING TO THE ABOVE TERMS AND CONDITIONS

CHILDS NAME_____CHILDS AGE _____

PARENT/GARDIAN SIGNATURE_____DATE _____

DO NOT WRITE BELOW THIS LINE --- DO NOT WRITE BELOW THIS LINE --- DO NOT WRITE BELOW THIS LINE