PEDIATRIC HISTORY FORM

PATIENT DEMOGRAPHICS

Today's Date _____/_____/____

Childs Name____ O Male O Female

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

Previous chiropractic care? Y/N Last visit:___/ ____/ _____ Reason for visit:__________________________

Who is responsible for costs associated with chiropractic care? _____________________________________

REASON FOR PURSUING CARE:

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***

____

____

When did the Problem first begin? Date ___/___/_____ __Unknown __Gradual __Sudden

Ever had this problem **before**? ___ No ___Yes If yes, when?_________________________________

Any **bowel or bladder** problems since this problem began?: If yes, describe:_________________________

____

Have you seen any **other doctors** for this problem? ___No ___Yes If yes, who?

____

How long ago? _____Days _____Weeks ______Months _____Years

What were the results of past treatment?____

How is this problem **NOW?:** O Rapidly Improving O Improving Slowly O About the Same

O Gradually Worsening O On & Off

Please list any **medication taken** for this problem: ____

Please list any present prescription drugs/doses:____

Please list any past prescription drugs/doses:____

Has your child ever sustained an injury playing organized sports? ___ No ___ Yes If yes, please explain:

____

____

1. Has your child ever sustained an injury in an auto accident? ___ No ___ Yes If yes; please explain:

____

____

BIRTH EXPERIENCE:

Your child's spine is very vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference).

Birth Height: _______ Birth Weight: _______ APGAR Scores: ___-___

Birth Intervention: ○ Forceps ○ Vacuum Extraction ○ C-Section (Planned) ○ C-Section (Emergency)

Breast Fed: Y/N How long?_____ Formula Fed: Y/N How long?_____

At what age was your child able to:
_____ Respond to stimuli _____ Cross Crawl _____ Sit up _____ Stand alone
_____ Respond to visual stimuli _____ Hold head up _____ Walk alone

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

☐ 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 ☐ Asthma
☐ Sinus Trouble ☐ Poor Posture ☐ Hypertension ☐ Walking Trouble
☐ Scoliosis ☐ Anemia ☐ Colds/Flu ☐ Sleeping Problems
☐ Bed Wetting ☐ Colic ☐ Broken Bones ☐ Fall on playground
☐ Fall off bicycle ☐ Fall from bed or couch ☐ Fall from crib ☐ Fall down stairs
☐Breast-feeding difficulty
☐ Allergies to____
☐ Other: ____

Is there anything else you would like us to know about your child? __________________________________
What are your health goals for your child?

____

Written Consent for a Child

Name of practice member who is a minor/child: ____

I authorize Dr. Vincent Cuviello and Dr. Chrisavi Cuviello and any and all of Amplify Chiropractic staff to perform diagnostic procedures, radiographic evaluation, render chiropractic care and perform chiropractic adjustments to my minor/child.

As of this date, I have the legal right to select and authorize health care services for my minor/child. If my authority to select and authorize care is revoked or altered, I will immediately notify Amplify Chiropractic.

______________________________ ______________________________

Date Guardian Signature

______________________________ ______________________________

Witness Signature (Office Staff) Guardian's relationship to minor/child

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 file. At your request, we will provide you a copy of your x-rays in our files.

The fee for copying your x-rays on a disc is $15.00. This fee must be paid in advance.
Digital x-rays on CD will be available within 72 hours of prepayment on any regular practice hours day. Please note: x-rays are used in this office to help locate and analyze vertebral subluxations. These x-rays are not used to investigate for medical pathology. The doctors of Amplify Chiropractic do not diagnose or treat medical conditions; however, if any abnormalities are found, we will bring it to your attentions so that you can seek proper medical advice.

By signing below you are agreeing to the above terms and conditions.

______________________________ ______________________________

Guardian Signature Print Your Name Here

______________________________ ______________________________

Your Age Signature

Female patients only: please read carefully and check the box, then sign below if you understand and have no further questions, otherwise see our team for further explanation.

○ To the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and/or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration, I therefore, do hereby consent to have diagnostic x-ray examination the doctor has deemed necessary in my case.

______________________________ ______________________________

Date Signature

Insurance Information

Please give your insurance card and driver's license to the front desk.

Childs Name: ___________________________________ Date: _____/_____/______

Name of primary insurance carrier: ____

Name of subscriber: ___________________________ Subscriber's date of birth:________________

Occupation: __________________________________ Employer: _____________________________

Subscriber's address: ____

Subscriber's phone number: _____________________

Policy number: ________________________________ Group number: ________________________

Do you have a HSA/FSA? (Health/Flexible Savings Account) ○ Yes ○ No

Name of secondary insurance carrier: ____

Name of subscriber: ___________________________ Subscriber's date of birth:_______________

Release of Authorization/Assignment of Benefits

I authorize and request payment of insurance benefits directly to Amplify Chiropractic: Chrisavi Cuviello, DC and Vincent Cuviello, DC. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the patient. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment.

_______________________________________ ____

Signature Date

Terms of Acceptance

In order to provide the most effective healing environment, most effective application of chiropractic procedures and the strongest possible doctor-patient relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic.

To that end, we ask that you acknowledge the following points regarding chiropractic care and the services that are offered through this clinic:

A. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art and practice. It is not the practice of medicine.
B. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of spinal subluxation(s). Subluxations are deviations from normal spinal structures and configurations that interfere with normal nerve processes.
C. The chiropractic adjustment process, as defined in the law of this jurisdiction, involves the application of a specific directional thrust to a region or regions of the spine with the specific intent of re-positioning misaligned spinal segments. This is a safe, effective procedure applied over one million times each day by Doctors of Chiropractic in the United States alone.
D. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If during this process, any condition or questions outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indications of the need.
E. Chiropractic does not seek to replace or compete with your medical, dental, or other types of health professionals. They retain responsibility for care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.
F. Your compliance with care plans, home and self-care, etc., is essential to maximum healing and optimal health through chiropractic care.
G. We invite you to speak frankly to the doctor on any matter related to your health care at this facility, its nature, duration, or cost, in what we work to maintain as a supporting open environment.

By my signature below, I have read and fully understand the above statements. All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my satisfaction. I therefore accept chiropractic care on this basis.

_______________________________________ _______________________________________

Signature Date