Point Family
Wellness and Chiropractic

Welcome to Point Family Wellness and Chiropractic! We will conduct a thorough history and physical examination to decide if we can assist you. If we do not believe that your condition will respond to chiropractic care, we will not accept you as a patient but will refer you to another health care provider, if appropriate.

Pediatric General Information

(Please Print in Black or Blue Ink) Today's Date:____/____/____

Child's Name: (First, MI, Last)____ Date of Birth:____/____/____

Home Phone: ____ Mobile Phone:____ Other Phone:____

Gender: ☐ Male ☐ Female Email:____ Contact Method *(check one)* ☐ H ☐ M ☐ O ☐ E@

SSN:____-____-____ Race: ☐ White ☐ Black/African American ☐ Hispanic ☐ Other____

Preferred Language: ☐ English ☐ Other____

Address:____ City, State, Zip:____

Mother's Name:____ Father's Name:____

Emergency Contact:____ Relationship:____ Phone:____

Appointment Reminders: ☐ Email ☐ Text

How were you referred:____

Has your child seen a Chiropractor before: ☐ Yes ☐ No

Insurance Information

☐ Insurance ☐ Cash

Insurance Company:____ Policy Number:____ Group Number:____

Relationship to the Patient: ☐ Self ☐ Parent/Guardian Policy Holder's Name:____

Policy Holder's Gender: ☐ Male ☐ Female Policy Holder's Date of Birth:____/____/____

Policy Holder's Address:____ City, State, Zip:____

History of Present Illness

Date of injury:____ Date Symptoms Appeared:____

What are your child's current complaints:____

How did your child's problem begin:____ ☐ Suddenly ☐ Gradual ☐ Post Injury

Has your child ever had the same condition: ☐Yes ☐ No Has your child seen another provider for this condition: ☐ Yes ☐ No

Since the condition began are the symptoms:

☐ Increasing ☐ Decreasing ☐ Not changing

What percent of the day are symptoms felt:

☐ 0 – 25 ☐ 25 – 50 ☐ 50 – 75 ☐ 75 – 100

What makes the symptoms better:

____

What makes the symptoms worse:

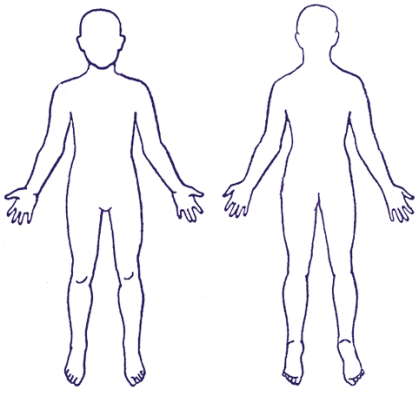
____

Rate the severity of the pain: *(0 = No Pain, 10 = A lot of Pain)*

0 1 2 3 4 5 6 7 8 9 10

Mark the areas on this body where your child feels the described sensations. Please use the appropriate symbols .

))))))	Aching
xxxx	Burning
oooo	Dull
: : : :	Sharp
/////	Stabbing
++++	Throbbing
*****	Numbness/Tingling



Pregnancy and Fertility History

Did mother have fertility issues: ☐ Yes ☐ No If yes, please describe:_____

Did mother smoke during pregnancy: ☐ Yes ☐ No Did mother drink alcohol during pregnancy ☐ Yes ☐ No

Did mother exercise during pregnancy: ☐ Yes ☐ No Was mother ill during pregnancy ☐ Yes ☐ No

Please explain any other concerns, complications or notable remarks about your child's conception or pregnancy: _____

_____

Labor and Delivery History

Type of Delivery: ☐ Vaginal ☐ Scheduled C-section ☐ Emergency C-section At how many week's was your child born:_____

Please check any applicable interventions or complications: ☐ Breech ☐ Induction ☐ Pain meds ☐ Epidural ☐ Episiotomy ☐ Vacuum extraction ☐ Forceps ☐ Other_____

Please explain any other concerns, complications or notable remarks about your child's labor and delivery:_____

_____

Child's birth weight:_____ Child's Birth height: _____ APGAR scores:_____

Growth and Development History

Is/was your child breastfed? ☐ Yes ☐ No If yes, how long:_____

Difficulty with breastfeeding? ☐ Yes ☐ No Formula introduced at age:_____

Did/does your child suffer from colic, reflux, or constipation as an infant: ☐ Yes ☐ No If yes, please explain:_____

_____

Did/does your child frequently arch their neck/back, feel stiff, or bang their head: ☐ Yes ☐ No If yes, please explain:_____

_____

Please list any food intolerance or allergies and when they began:_____

_____

Have you chosen to vaccinate your child: ☐ Yes, on schedule ☐ Yes, on a delayed schedule ☐ No

If yes, please list any vaccination reactions:_____

Has your child received any antibiotics: ☐ Yes ☐ No If yes, how many times and list reason:_____

_____

Did/does your child have night terrors, sleepwalking or difficulty sleeping: ☐ Yes ☐ No If yes, please explain:_____

_____

Did/does your child have any behavioral, social, or emotional issues? ☐ Yes ☐ No If yes, please explain:_____

_____

How many hours per day does your child typically spend watching a TV, computer, tablet, or phone:_____

How would you describe your child's diet: ☐ Mostly whole, organic foods ☐ Pretty average ☐ High amount of processed foods

Social History

What are your child's hobbies:_____

Does your child exercise: ☐ Yes ☐ No If yes, in what way and how often:_____

Medical History

Please list any Hospitalizations, Auto Accidents, Surgeries, Serious Illness, or Serious Injuries:

Date:_____Briefly Explain:_____

Date:_____Briefly Explain:_____

Please list any known allergies:_____

Current Medications and Supplements: *(Please include prescription and over the counter medications)*

Medication	Reason	Supplements	Reason

Family Health History

Please indicate if a family member (parent or sibling) has had or currently has any of the following conditions:

☐ Arthritis ☐ High Blood Pressure ☐ High Cholesterol ☐ Heart Disease ☐ Stroke ☐ Diabetes ☐ Cancer

If deceased, please list cause of death:_____

Medical Conditions

Please indicate if your child has had or presently has any of the following conditions: ☐ Acid Reflux ☐ ADD/ADHD

☐ Allergies ☐ Anxiety ☐ Arthritis ☐ Asthma ☐ Autism ☐ Bedwetting ☐ Bipolar ☐ Cancer ☐ Colic

☐ Constipation ☐ Depression ☐ Diabetes ☐ Ear Infections ☐ Headaches ☐ Seizures ☐ Sensory Processing Disorder

☐ Sinus Infections ☐ Other_____

Health Goals

What are your top three health goals for your child:

1._____ 2. _____ 3._____

What would you like to gain from chiropractic care? ☐ Resolve existing condition ☐ Overall wellness ☐ Both

Do you have any health concerns for other family members today?_____

Are you open to other therapies to help improve your child's care? ☐ Acupuncture ☐ Massage ☐ Nutrition

Signature

I certify this information is true and correct to the best of my knowledge. I will notify Point Family Wellness and Chiropractic of any changes in my status or the above information. I consent to a chiropractic evaluation and treatment by the doctor.
I understand that any fee for service rendered is due at the time of service.

Patient Signature:_____ Date:_____

Guardian Signature:_____ Date:_____

Physician Signature:_____ Date:_____

Vitals (OFFICE USE ONLY)

Height:_____ Weight:_____ Pulse:_____ Resp:_____ Temp:_____ BP:_____/_____ BMI:_____