CHILDREN'S HISTORY FORM

Name:_____ Date: _____
Street Address:_____City/State:_____Zip:_____
Date of Birth:_____/_____/_____ Age:_____ Height:_____ Weight:_____
Father Cell phone:_____/_____/_____ Mother Cell phone:_____/_____/_____
Father's Name: _____ Mother's Name: _____
Guardian: _____ Who referred you here?_____

COMPLAINTS/HEALTH PROBLEMS

☐ My child is here for a general health evaluation. ☐ My child is suffering from a particular health problem.
Please describe your child's complaints, including when and how they started:

_____
_____
_____
_____
_____
_____
_____

What treatments and tests has your child received for his/her problems so far?

_____
_____

Has your child ever seen a chiropractor? __ Y __ N Who? _____
Who is your child's pediatrician? Name: _____ Location: _____
When is the last time your child visited his/her pediatrician? Date:_____
Reason: _____
Please list any major childhood traumas with dates and hospitalizations.

_____
_____

Is your child taking any over the counter or prescription drugs? _____
_____
Is your child taking any vitamins/supplements? _____
What illnesses has your child had (measles, chicken pox, etc.)? _____
Check any of the following conditions your child has or had:

__ Allergies__ Drug Allergies	__ Eczema	__ Neck Pain
__ Sinus Problems	__ Other Skin Problems	__ Mid Back Pain
__ Asthma	__ Headaches	__ Low Back Pain
__ Anemia	__ Migraines	__ Shoulder Pain L R
__ Arthritis	__ Heart Disease	__ Elbow Pain L R
__ Cancer	__ Heart Attack	__ Hand Pain L R
__ Depression	__ Menstrual Problems	__ Hip Pain L R
__ Diabetes	__ Multiple Sclerosis	__ Leg Pain L R
__ Digestive Problems	__ Stroke	__ Knee Pain L R
__ Drug Abuse/Addiction	__ Weight Problems	__ Foot Pain L R
__ Alcoholism	__ Ringing in Ears	__ Carpal Tunnel L R
__ Stress	__ Dizzy/Balance Problems	__ Other _____

__ ADD ADHD Autism Asperger's syndrome Tourette's syndrome Dyslexia Dyspraxia

Siblings, ages, and health: _____

Patient name printed _____ DOB _____

☐ Yes ☐No Any personality/emotional changes? If so, what? _____
☐ Yes ☐No Any sense of smell changes? _____
☐ Yes ☐No Any spots or disturbances to vision? _____
☐ Yes ☐No Does your heart feel like it races? _____
☐ Yes ☐No Any changes in bowel/bladder function? _____
☐ Yes ☐No Any short or long-term memory changes? _____
☐ Yes ☐No Any changes in your energy level-fatigue? _____
☐ Yes ☐No Any muscle twitches? _____
☐ Yes ☐No Does your child exercise regularly? If so, what? _____

A healthy eater? **Y N** An unhealthy eater? **Y N** Somewhere in-between? **Y N**
Can they eat anything they want? **Y N** If not, what is avoided? _____
Any regular soda? **Y N** Diet soda/drinks? **Y N** If yes, how many/day? _____
Any caffeine consumed (coffee, soda, tea)? **Y N** If so, how much? _____

CHILD CONSENT TO TREATMENT AUTHORIZATION

I, the undersigned, being the parent/guardian of _____, certify that the above information is correct. I authorize Fuller Chiropractic to perform an examination, take x-rays if necessary, and administer chiropractic treatment for this child. I authorize Fuller Chiropractic to contact and release information to other health care providers the child has to coordinate care, and to release health information for insurance reimbursement purposes.

Parent/Guardian Signature **(X)** _____ Date _____

INSURANCE ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR

I hereby instruct and direct _____ Insurance Company to make payment directly to: **FULLER CHIROPRACTIC, 827 Main Street, Woburn, MA 01801,** the professional or chiropractic benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.
A photocopy of this Assignment shall be considered as effective and valid as the original dated at Woburn,

Massachusetts this _____ day of _____ 20_____.

Parent Signature **(X)** _____

By my signature below, I understand that if my health insurance denies the charges, I am responsible for payment of my bill.

Parent Signature **(X)** _____

PRIVACY NOTICE ACKNOWLEDGEMENT

We are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the *Health Insurance Portability and Accountability Act* of 1996 (HIPAA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them. I acknowledge that I have been offered a copy of Fuller Chiropractic, P.C.'s Notice **of Privacy Practices for Protected Health Information**, and I have been told that a copy is available at the front desk at any time.

Patient Signature **(X)** _____ Date _____

Patient name printed _____ DOB _____

PATIENT PREGNANCY DISCLAIMER (FEMALES OF CHILDBEARING AGE)

This certifies that concerns regarding pregnancy and radiation exposure have been explained to my satisfaction. I understand the clinical necessity of having X-rays taken for my child and grant permission for this procedure. In so doing, I release the doctor/clinic from responsibility for potential damage arising from this procedure. At the present time,

_____ I am sure my child is not pregnant.
_____ It is possible my child could be pregnant.
_____ My child is pregnant.

Parent Signature **(X)** _____ Date _____

NOTE: Female patients should be questioned as to the last date of their menstrual cycle and the 10-day rule should always be applied for protection of the patient and possibly the fetus.

Authorized Provider Representative _____ Date _____
Witnessing signing of: ☐ Authorization to treat ☐ Insurance assignment ☐ Privacy Notice ☐ Pregnancy Disclaimer

Notes: