Pediatric New Patient Health History Form

In order to provide you the best possible wellness care, please complete this form.
All information is strictly CONFIDENTIAL.

Patient Data

First Name:______________________ Last Name: _________________________________ Today's Date: ____________________

Address: ____ City: ________________________ State:______ Zip:_______________

Mother's Name: ____________________________________ Mother's Employer: ____________________________________

Mother's Phone: (H): __________________________(C): __________________________ (W): ______________________________

Father's Name: ______________________________________ Father's Employer: ____

Birth Date: ______________________ Social Security #: _____________________________ # of Siblings: ___________________

How were you referred? ____

Do you prefer morning or afternoon appointments? ____

The Birth

Age of Patient: ______ yrs ______ months Sex: ____F ____M

Birth Weight: ____________ Birth Length ______________Current Weight _______________ Current Length ______________

Was the Birth: ____ Normal _____ Breech _____ Cesarean ______Home Birth _____ Vacuum Extraction _____ Forceps

Where was the Birth: _____Hospital ______________________________ ____ Birthing Center _____________________________

Any pregnancy problems: ____

____

Congenital (Birth) Defects/Anomalies? ____

____

Was there Presence at Birth: _____ Meconium ____ Cyanosis(Blue) ____ Jaundice (yellow)

Pediatrician/Family MD ____

Obstetrician/Midwife ____

Immunization Dates: Hep B ________________ OPV_________________________ MMR______________________

DTP _________________ HIB F_______________________ VAR _______________________

Childhood Diseases: Measles _______________ Mumps_______________________ Chicken Pox_________________

Whooping cough _____________ Other______________________

Date and Purpose of Last MD Visit: ____

Has this Child Been Treated for an Emergency? ____ Yes ____ No Describe____

____

Surgeries ____

Medications and Vitamins ____

Accidents (Even Minor) ____

Have this child ever been under chiropractic care? NO ____ YES ____

Has this Child Ever Suffered From:	
____ Allergies	____ Heart Troubles
____ Anemia	____ High Blood Pressure
____ Arthritis	____ Hyperactivity
____ Asthma	____ Irregular Heart Beat
____ Arm Problems	____ Joint Problems
____ Backaches	____ Leg Problems
____ Bed Wetting	____ Muscle Jerking
____ Bronchitis	____ Neck Problems
____ Behavior Problems	____ Neuritis
____ Cancer	____ Orthopedic Problem
____ Constipation	____ Paralysis
____ Convulsions	____ Poor Appetite
____ Diabetes	____ Rheumatic Fever
____ Digestion Problems	____ Ruptures/Hernias
____ Dizziness	____ Sinus Trouble
____ Earaches	____ Sleep problems
____ Fainting	____ Spinal Curvatures
____ "Growing Pains"	Other
____ Headaches	____

Has this child ever:	No	Yes	Briefly Explain
Broken Bones?			
Been Hospitalized?			
Been in an Auto Accident?			
Been Unconscious?			
Had Surgery?			

Family History

Family Members – Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.

____

____

____

Insurance Information:

Does this child have health insurance? ____ NO ____ YES Name of company

____

*If an auto accident, please provide: (Please bring a copy of the accident/police report)

Insurance Company Name: ______________________________ Contact Person: ___________________________

I CERTIFY THE INFORMATION PROVIDED IS ACCURATE TO THE BEST OF MY KNOWLEDGE.
I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Signature of Legal Guardian:

____Date:__________________________

Legal Guardian Printed Name/Relationship to patient:

___

CONSENT FOR EXAMINATION AND TREATMENT OF MINOR CHILD

I hereby authorize the Gina Lehman D.C. and whomever she may designate as her assistant to examine and administer treatments as deemed necessary to my child ____.

(please print child's name)

Our office strives to deliver the best care and will coordinate care with your child's pediatrician by sending records regarding their care if need be. This will improve care by opening lines of communication and allow your child's pediatrician to report important health related information to our doctor.

Printed name of person authorizing treatment: ____

Signature: ____

Date: ___________________________ Relationship to Child: ____________________________________