PEDIATRIC CONFIDENTIAL HEALTH INFORMATION

Head to Toe
HEALTH & WELLNESS
117 W. Main Street Peotone, IL 60468
(708) 258-9600 **www.peotonewellness.com**

Date _____

Child's Name _____

Parent/Guardian's Name(s) _____

Address _____ City _____

State _____ Zip _____ Phone Number _____

Email _____ Child's SS# _____

Birthdate _____ Age _____

How did you hear about us? _____

Who is your child's pediatrician? _____

Is your child receiving care from any other health professionals? _____

If yes, please state their specialty? _____

Any drug/medications/vitamins/herbs your child is taking? _____

_____

Current Health Conditions

What health condition(s) bring your child in today? _____

_____

When did the condition start? _____

Has your child been seen for this condition before? _____

What makes the problem better? _____

What makes the problem worse? _____

Health Goals for your Child

1. _____
2. _____
3. _____

Have you or your child ever visited a chiropractor before? _____

If yes, what is their name? _____

Pregnancy & Fertility History

Any fertility issues? _____ If yes, please explain _____

Did mother smoke? _____ If yes, how many per week _____

Did mother drink? _____ If yes, how many per week _____

Did mother exercise? _____ If yes, please explain _____

Was mother ill? _____ If yes, please explain _____

Please explain any notable episodes of mental or physical stress during your pregnancy: _____

_____

_____

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

_____

_____

Consultation Notes

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_____
Doctor's Initials

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Health & Wellness

Labor and Delivery History

Patient Name _____

Child's birth was: Natural Vaginal _____ Scheduled C-section_____ Emergency C-section_____

Child was born: At home _____ At a birthing center _____ At a hospital _____

Other:_____

Doctor/Obstetrician's Name: _____

Please check any applicable interventions or complications about labor and delivery:

Breech_____ Induction_____ Pain Meds_____ Epidural_____ Episiotomy _____

Vacuum extraction _____ Forceps _____ Other _____

Please describe any other concerns about labor and delivery. _____

_____

Child's Birth Weight _____ Child's Birth Height _____

APGAR score at birth_____ APGAR score after 5 minutes _____

Growth and Development History

Is/was your child breast feed? ☐ Yes ☐ No If yes, how long? _____

Difficulty Breastfeeding? ☐ Yes ☐ No

Did they ever use formula? ☐ Yes ☐ No If yes, at what age? _____

If yes, what type?_____

Did/does your child frequently arch their neck/back, feel stiff, or bang their head? Yes No

If yes, explain_____

At what age did the child: Respond to sound _____ Follow an object _____

Hold their head up _____ Vocalize _____ Teethe _____Sit alone _____

Crawl _____ Walk _____ Begin Cow's Milk _____ Begin solid foods _____

Consultation Notes

Please list any intolerances or allergies, and when they began:

_____

_____

Please list hospital and surgeries including the year:

_____

Please list any major injuries, accidents, falls and fractures including the year:

_____

_____

Have you chosen to vaccinate your child ☐ Yes ☐ No

If yes, Vaccinate _____ On Schedule _____ Delayed or selective Schedule

Please list any vaccination reactions _____

Has your child received any antibiotics ☐ Yes ☐ No

If yes, how many times and for what reasons _____

Night Terrors or difficulty sleeping ☐ Yes ☐ No

If yes, please explain_____

Behavioral, social or emotional issues? ☐ Yes ☐ No

If yes, please explain _____

How many hours a day does your child typically have access to 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

_____

Doctor's Initials

Patient Name _____

Acknowledgements
To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials _____
I instruct the chiropractor to deliver the care that, in his or her professional judgment, can best help my child in the restoration of his/her health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

Initials _____
I may request a copy of the privacy policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

Initials _____
I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.

Initials_____
I acknowledge that any insurance I may have is an agreement between carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

Initials _____
To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

Initials _____
Our cancellation Policy: patients are responsible for cancelling or rescheduling their appointments in a timely matter, otherwise a $25 fee may be assessed for all “no show” or missed appointments.

Acknowledgement and Consent

Parent/Guardian’s Signature: _____ Date: _____

_____
Doctor’s Initials

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