PARKWOOD
FAMILY CHIROPRACTIC

NEW PATIENT HEALTH HISTORY
CHILDREN UNDER 10

8380 Warren Parkway
Suite 601
Frisco, TX 75034
972.437.8040

PATIENT INFORMATION

Name (First, Middle, Last) _____ Preferred Name_____

Address _____

City, State, Zip Code _____

M F Age _____ Birthday (mm/dd/yy) _____ Social _____

Parents' Marital Status S M W D (circle one) Appointment Date _____

Parent Email Address _____

Mom's Cell Phone _____ Dad's Cell Phone _____

Preferred Method(s) of Contact _____

Mom's Name _____ Occupation _____

Employer _____

Dad's Name _____ Occupation _____

Employer _____

Siblings (Names & Ages) _____

Referred to PFC By _____

IN CASE OF EMERGENCY PLEASE CONTACT:

Name (First & Last) _____ Relationship to Patient _____

Cell Phone _____ Other Phone _____

INSURANCE INFORMATION

Primary Insurance _____

Personal ID No. _____ Group No. _____

Customer Service # _____ Relationship to Primary_____

Primary Subscriber _____ Birthday (mm/dd/yy) _____

Do you have an HSA or FSA? (Health Savings Account/Flexible Spending Account)_____

Do you have an HRA? (Health Reimbursement Account) Used $ _____ Remaining$ _____

Secondary Insurance _____

Personal ID No. _____ Group No. _____

Customer Service # _____ Relationship to Primary_____

Primary Subscriber _____ Birthday (mm/dd/yy) _____

ASSIGNMENT AND RELEASE:
I, the undersigned, certify that I (or my dependant) have insurance coverage with _____ and assign directly to Benjamin Wagley, D.C. all insurance benefits payable for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature _____ Date _____

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WHY THIS FORM IS IMPORTANT

As a family chiropractic office, we focus on your child's health potential. The more information we have, the better we can care for your family. We have two primary goals for your child:

1. To address any issues that brought you to our office
2. To offer you and your child the opportunity for improved health potential and wellness services.

Please complete ALL FIVE pages of this health history form.

PAST CHIROPRACTIC EXPERIENCE

Has your child ever been seen by a chiropractor? (Date or Date Range)_____

Dr. Name / Practice _____

What was your child's primary reason for seeing the chiropractor?_____

Were you offered a wellness care plan to improve your child's health?_____

Was your child able to follow the doctor's recommendations?_____

Why are you changing chiropractors for your child?_____

WELLNESS CARE

If your child has no symptoms or concerns and is here for wellness care, please initial below:

_____ (Initials of responsible party)

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PRIMARY HEALTH CONCERN

What is the PRIMARY reason for your child's visit? _____

How long has your child suffered with this? _____

How did this condition begin? _____

If symptoms are present they feel like: (circle all that apply)

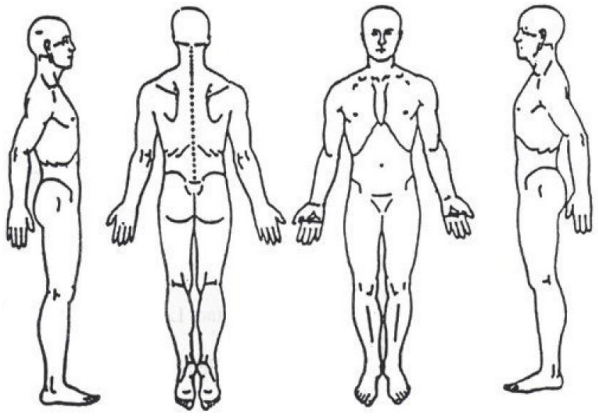
Aching Sharp Dull Burning Shooting Numbness
Tingling Throbbing Cramping Stiffness Weakness

Are symptoms worse at certain times of day? _____

What percentage of the day does he/she have symptoms? _____

What makes symptoms worse? _____

What makes symptoms better? _____



Please circle areas where symptoms are present.

Next to each circle, please rate the symptom on a scale of 1-10
(10 = most severe, 1 = least severe)

OTHER HEALTH CONCERNS

Please list any other health concerns or pain that your child is currently experiencing:

_____

_____

_____

_____

_____

_____

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PREGNANCY, BIRTH & DELIVERY		COMMENTS
Full term	Y N	
Complications during pregnancy	Y N	
Prescriptions during pregnancy	Y N	
Vitamins/Herbs during pregnancy	Y N	
OTCs used during pregnancy	Y N	
Midwife used	Y N	
Obstetrician used	Y N	
Did mom smoke during pregnancy	Y N	
Alcohol during pregnancy	Y N	

PREGNANCY, BIRTH & DELIVERY (cont.)		COMMENTS
Recreational drugs during pregnancy	Y N	
Where was baby born (type of facility)		
Vaginal delivery or C-Section		
Devices used – forceps/vacuum	Y N	
Length of labor		
Length of delivery		
Was mom induced	Y N	
Oxytocin/pitocin used	Y N	
Epidural administered	Y N	

BABY/TODDLER YEARS – BIRTH TO 4 YEARS		COMMENTS
Did mom breastfeed – how long	Y N	
Formula used – brand & age begun	Y N	
Age solid foods introduced		
Age grains introduced (rice, wheat, etc.)		
Eat fruit & vegetables daily	Y N	
Drink enough water	Y N	
Drink juice – age introduced	Y N	
Consume dairy – age introduced	Y N	
Consume frequent sweets	Y N	
Consume sugar substitutes	Y N	
OTC drug use	Y N	
Prescription drug use	Y N	
Vitamins/herbs	Y N	
Frequent physical activity/play	Y N	
Sleep irregularity	Y N	
Fall from change table or crib, etc.	Y N	
Involved in car accident	Y N	
Appropriate weight gain/growth	Y N	
Vegetarian	Y N	
Picky eater	Y N	

CHILDHOOD YEARS – 5 TO 10 YEARS		COMMENTS
Eat vegetables daily	Y N	
Eat fruits daily	Y N	
Drink enough water	Y N	
Consume dairy	Y N	
Consume frequent sweets	Y N	
Consume sodas – frequency	Y N	
Consume juice – frequency	Y N	
Consume sugar substitutes	Y N	
OTC drug use	Y N	
Prescription drug use	Y N	
Vitamins/herbs	Y N	
Youth sports/activities	Y N	
Frequent physical activity/play	Y N	
Sleep irregularity	Y N	
Fall from bicycle, tree, etc.	Y N	
Sports accident	Y N	
Learning difficulties	Y N	
Appropriate weight gain/growth	Y N	
Vegetarian	Y N	
Picky eater	Y N	

SYMPTOM HISTORY (if applicable)	CURRENT (✓)	AGE RANGE	COMMENTS
Frequent crying spells or colic			
Constipation/diarrhea/stomach pain			
Frequent fevers			
Frequent ear infections			
Frequent tonsilitis/colds			
Headaches			
Seasonal allergies			
Food allergies			
Asthma			
ADD/ADHD or Hyperactivity			
Diagnosed with Autism			
Bedwetting			
Reaction to vaccination			
Numbness or tingling in hands/arms/legs			
Foot/ankle/or knee pain			
Back/shoulder/or neck pain			
Wrist/arm pain			
Ringing in ears			
Dizziness or fatigue			
Growing pains			

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CURRENT MEDICATIONS	HOW LONG TAKEN	COMMENTS

HOSPITAL STAYS/SURGERIES	APPROXIMATE DATE	COMMENTS

DIAGNOSIS HISTORY		
OTHER THAN COMMON COLDS/FLU, ETC., PLEASE LIST ANY CONDITIONS WHICH YOUR CHILD HAS BEEN DIAGNOSED WITH – PAST OR PRESENT:		
DIAGNOSIS	APPROXIMATE DATE	COMMENTS

VACCINE SCHEDULE (circle one)		
TRADITIONAL	ALTERNATIVE	NO VACCINES

ANTIBIOTICS GIVEN FROM BIRTH TO PRESENT (circle one)		
FREQUENT	RARE	NEVER

ADDITIONAL NOTES REGARDING HISTORY OR HEALTH

I hereby certify that the statements and answers given are accurate to the best of my knowledge, and I understand that it is my responsibility to inform this office of any changes in my child's health.

Child's Name (printed name) _____ Parent's Name (printed) _____ Signature _____ Date (mm/dd/yy) _____