

# SCHARENBERG CHIROPRACTIC OFFICES

## PEDIATRIC HEALTH HISTORY

Patient Name \_\_\_\_\_ Nick Name \_\_\_\_\_ Date \_\_\_\_\_  
SS# \_\_\_\_\_ Birth Date \_\_\_\_\_ Sex M F Name of Parents/Guardians \_\_\_\_\_  
Address City State Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Parent's Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Email Address \_\_\_\_\_ Referred by \_\_\_\_\_

### Consultation

Reason for seeking chiropractic care: \_\_\_\_\_  
When did the problem begin? \_\_\_\_\_  
Is this problem  Occasional  Frequent  Constant  Intermittent  Other \_\_\_\_\_  
Does the problem radiate? No Yes If yes, where? \_\_\_\_\_  
What makes it worse? \_\_\_\_\_  
What makes it better? \_\_\_\_\_  
Is the problem worse during a certain time of the day? No Yes If YES, when? \_\_\_\_\_  
Does this interfere with the child's  Sleep  Eating  Daily routine? Is this becoming worse? No Yes  
If yes, how? \_\_\_\_\_  
Other professionals seen for this condition? \_\_\_\_\_  
Results with treatment? \_\_\_\_\_

### Prenatal History

Name of Obstetrician/Midwife \_\_\_\_\_  
Complications during pregnancy: No Yes List: \_\_\_\_\_  
Ultrasounds during pregnancy: No Yes How Many: \_\_\_\_\_  
Location of Birth:  Hospital  Birthing Center  Home  
Birth intervention:  Forceps  Vacuum  Caesarian: Planned or Emergency  
Complications during delivery: No Yes \_\_\_\_\_  
Medications during pregnancy: No Yes List: \_\_\_\_\_  
Medications during delivery: No Yes List: \_\_\_\_\_  
Cigarette / Alcohol use during pregnancy: No Yes  
Was the infant alert and responsive within 12 hours of delivery? No Yes  
If No, please explain \_\_\_\_\_  
Birth weight \_\_\_\_\_ Birth length \_\_\_\_\_ APGAR scores \_\_\_\_\_  
Genetic disorders or disabilities? \_\_\_\_\_  
Breast Fed: No Yes How long? \_\_\_\_\_ Formula fed: No Yes How long? \_\_\_\_\_  
Solids at \_\_\_\_\_ months Cow's milk at \_\_\_\_\_ months Food/juice allergies or intolerances No Yes  
Anything else that needs to be noted: \_\_\_\_\_

At what age did the child: Respond to sound \_\_\_\_\_ Follow an object \_\_\_\_\_ Hold head up \_\_\_\_\_  
Vocalize \_\_\_\_\_ Sit alone \_\_\_\_\_ Crawl \_\_\_\_\_ Walk \_\_\_\_\_ Sleep Through Night \_\_\_\_\_  
Do you consider your child's sleeping pattern normal? No Yes Number of hours sleeping per night \_\_\_\_\_

### Medication History

Previous Chiropractor: \_\_\_\_\_ Date of last visit & Reason: \_\_\_\_\_  
Name of Pediatrician: \_\_\_\_\_ Date of last visit & Reason: \_\_\_\_\_

Are you satisfied with the care your child received there? Yes No  
Immunization history: \_\_\_\_\_  
Reactions: \_\_\_\_\_  
Check all drugs your child is taking including prescription and non-prescription drug  
 Asthma medication  Tylenol  Advil/Ibuprofen  Cold tablets  Allergy Med  
 ADHD Med  Painkillers  Anti-Depressants  Other \_\_\_\_\_  
Does your child take any Vitamins or Herbs? No Yes \_\_\_\_\_  
Number of antibiotics your child has taken: Past 6 months \_\_\_\_\_ Total during his/her lifetime \_\_\_\_\_

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## Falls & Injuries

According to the National Safety Council, 50% of children fall head first from a high place during their first year of life (i.e., a bed, changing table, down stairs, etc.).

Is this the case with your child? No Yes

When was your child's most recent fall? \_\_\_\_\_ What happened? \_\_\_\_\_

Which of the following sports have your child been involved in?

Football     Basketball     Soccer     Gymnastics/Cheerleading     Martial Arts  
 Running     Horseback riding     Other: \_\_\_\_\_

Has your child ever broken a bone if so, which one? \_\_\_\_\_

Has your child ever been involved in an auto accident? No Yes Was there impact? No Yes

Were there injuries? No Yes (Dates/any treatment) \_\_\_\_\_

Has your child ever been seen on an emergency basis? No Yes (please list all) \_\_\_\_\_

Other traumas not described above? No Yes \_\_\_\_\_

Prior surgery: No Yes If yes, Type and Date: \_\_\_\_\_ Menses: No Yes Age: \_\_\_\_\_

## Childhood Diseases & Illness

<input type="checkbox"/> Acid Reflux	<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Allergies	<input type="checkbox"/> Anemia
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Asthma	<input type="checkbox"/> Autism	<input type="checkbox"/> Backaches
<input type="checkbox"/> Bed Wetting	<input type="checkbox"/> Behavioral Problems	<input type="checkbox"/> Blood Disorders	<input type="checkbox"/> Broken Bones
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Car Accident	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Chronic Colds
<input type="checkbox"/> Chronic Earaches	<input type="checkbox"/> Colic	<input type="checkbox"/> Constipation	<input type="checkbox"/> Convulsions
<input type="checkbox"/> Depression	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Digestive Problems
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Ear Infections	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Fainting
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Growing Pains	<input type="checkbox"/> Headaches	<input type="checkbox"/> Heart Trouble
<input type="checkbox"/> Hernias	<input type="checkbox"/> Hyperactivity	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Jaundice
<input type="checkbox"/> Loss of Balance	<input type="checkbox"/> Loss of Smell	<input type="checkbox"/> Mumps	<input type="checkbox"/> Neck Pains
<input type="checkbox"/> Poor Appetite	<input type="checkbox"/> Poor Coordination	<input type="checkbox"/> Recurring Fevers	<input type="checkbox"/> Rubella
<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Seizures	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Sinus
<input type="checkbox"/> Sore Throats	<input type="checkbox"/> Stomach Aches	<input type="checkbox"/> Temper Tantrums	<input type="checkbox"/> Urinary Problems
<input type="checkbox"/> Walking Problems	<input type="checkbox"/> Whooping Cough	<input type="checkbox"/> Other: _____	

## Authorization To Treat A Minor

I \_\_\_\_\_, Parent or legal Guardian of \_\_\_\_\_  
YOUR NAME (PRINT) CHILD'S NAME

Hereby authorize D.R. Scharenberg, D.C. and his staff to administer chiropractic care to my son or daughter as they deem necessary. As of this date, I have the legal right to select and authorize health care services for the minor child. Under the terms and conditions of my marriage, divorce, separation, or other legal authorization the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

**Insurance Information**

Who is responsible for this account? \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Group # \_\_\_\_\_

Is patient covered by additional insurance?  Yes  No

Subscriber's Name \_\_\_\_\_

Birthdate \_\_\_\_\_ SS # \_\_\_\_\_

Relationship to the Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Group # \_\_\_\_\_

**Assignment and Release**

I certify that I, and/or my dependent(s), have insurance coverage with \_\_\_\_\_ and assign directly to Dr. Scharenberg all insurance

(NAME OF INSURANCE COMPANY(IES))

benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed or one year for the date signed below.

\_\_\_\_\_  
Signature of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Please print Name of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient