Welcome to Portolese Family Chiropractic!

Patient Name: _____ Patient Number: _____ Date: _____

Please complete this detailed history form in order for us to provide you with the best possible care. Please let us know if you should require any assistance while doing so.

Patient Information

Child's Name:_____Nickname?_____
Male/Female:_____ Age:_____ Birthday:_____ Weight:_____ Height:_____
Address:_____City/State/Zip:_____
Names and ages of siblings:_____

Parent/Guardian Information

Name(s):_____
Address (if different from child's):_____
Home Phone Number:_____Cell Phone Number:_____
Parent's Occupation:_____Work Phone Number:_____

Insurance Information

Who is responsible for this account?_____Relationship to patient:_____
Insurance Co:_____ Group Number:_____
Subscriber's Name:_____ Subscriber's SS#:_____
Is the patient covered by additional insurance? Y/N:_____ If yes, please provide the same information on the lines below:
Insurance Co:_____ Group Number:_____
Subscriber's Name:_____ Subscriber's SS#:_____

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____and assign directly to Dr. Tammy L. Portolese all insurance 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 hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.
Signed:_____
Date:_____

Many health challenges are associated with physical, mental and chemical stressors that a child has experienced. *This health record is designed to help us understand the stressors your child may have experienced, in order to maximize his/her health.*

Reason for this visit:_____
Have you seen other doctors regarding this?_____Y _____N If so, whom?_____
What was the outcome of treatment?_____
List any medications (including OTC) taken for this condition:_____
Date these symptoms first appeared:_____ Is it getting worse? _____Y _____N _____Unknown
Onset was: (circle one) Sudden Gradual Associated with an event (describe event) _____
These symptoms are: (circle one) Constant Intermittent Occasional Cyclical
How does your child describe these symptoms? _____
What initiates these symptoms?_____
Relieves them?_____ Aggravates them?_____
How does this problem interfere with your child's function and daily activities?_____
_____
Prior occurrences or episodes relevant to this condition:_____
What are your chief concerns regarding your child's health and well-being?_____

Patient Name: Patient Number: Date:

The Pregnancy Process

During pregnancy, did the mother:

Take Medication?_____ If yes, what type?_____

Smoke?_____ Consume Alcohol?_____ Drugs?_____ Describe:_____

Take supplements? _____ List:_____

Become ill?_____ How? _____ Undergo a lot of stress?_____

Receive ultrasound or other radiation?_____ If yes, how many?_____ Medical reason?_____

Have problems with the pregnancy?_____ If yes, describe:_____

The Birthing Process

Birth Location: ☐ Hospital ☐ Birthing Center ☐ Home Birth Assistants: ☐ Doctor ☐ Midwife ☐ Doula

Type of Birth: ☐ Vaginal ☐ Forceps ☐ Vacuum/Suction ☐ Induced ☐ C-section (circle one): planned / emergency

Baby Presentation at Birth (or 3rd trimester☺ ☐ Head first (cephalic) ☐ Breech ☐ Posterior (facing forward) ☐ Transverse

Did the mother: (check all that apply) ☐ Take Medication, type_____ ☐ Have an epidural ☐ Episiotomy

How long was labor? _____ Were there complications?_____

What was the mother's position during labor?_____ Who else was present?_____

What was the child's gestational age at birth?_____ Birth Weight:_____ Length:_____

APGAR Score at Birth:_____ After 5 minutes: _____ Jaundice? _____ Cyanosis?_____

Congenital abnormalities or defects? _____ Explain: _____

Was your child subjected to any of the following? ☐ Silver Nitrate eye drops ☐ Vitamin K injection ☐ Hepatitis injection

☐ Incubation (how long)_____ ☐ Separation from the mother (how long) _____

Was the child alert & responsive within 12 hours of delivery? ☐ Yes ☐ No, Explain:_____

Vaccination History

Did you choose to vaccinate your child? ☐ Yes ☐ No

If yes, please check all vaccinations received: ☐ DPT ☐ MMR ☐ Polio ☐ Chicken Pox ☐ Hepatitis ☐ Flu

☐ Other_____ Please describe your child's reaction to these vaccines: _____

Growth and Development

Was the child breastfed?_____ How long?_____ Any difficulties?_____

At what age was formula introduced?_____ Type:_____ Cow's Milk?_____ Solid Foods?_____

Has your child had antibiotics? ☐ Yes ☐ No If yes, which ones and why? _____

At what age did the child:

Respond to sound?_____ Follow an object?_____ Hold up head?_____ Sit unassisted?_____

Crawl?_____ Vocalize?_____ Teethe?_____ Walk?_____

Has your child ever had any of the following? (check all that apply)

☐ Headaches	☐ Irritability	☐ Constipation	☐ Seizures/convulsions
☐ Dizziness	☐ Hyperactivity	☐ Colic	☐ Heart trouble
☐ Allergies	☐ Frequent Colds	☐ Rashes	☐ Joint problems
☐ Ear Problems	☐ Flu	☐ Food Intolerances	☐ Scoliosis
☐ Eye Problems	☐ Bloody Noses	☐ Bed wetting	☐ Anemia
☐ Sleeping disorders	☐ Asthma	☐ Digestive Problems	☐ Hypertension
☐ Breathing Problems	☐ Meningitis	☐ Poor Posture	☐ Broken bones
☐ Fatigue	☐ Diarrhea	☐ Learning Disorders	☐ Muscular problems

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According to the National Safety Council, approximately 50% of all children fall head first from a high place during their first year of life (changing table, bed, high chair, etc.) Was this the case with your child? ☐ Yes ☐ No

Has your child ever….

Fallen from heights over 2 feet? ☐ Yes ☐ No Been hospitalized? ☐ Yes ☐ No

Been in a motor vehicle accident? ☐ Yes ☐ No Suffered a brain injury? ☐ Yes ☐ No

Suffered a sports injury? ☐ Yes ☐ No Played high impact or contact sports? ☐ Yes ☐ No

Suffered any trauma not listed above?_____

Is your child accident-prone? ☐ Yes ☐ No Any pets in the home? ☐ Yes ☐ No Smokers in the home? ☐ Yes ☐ No

Physical Activity and Childhood Nutrition

Approximate # of hours of physical activity/ play time each week:_____ # of hours of TV/computer each week:_____

Does your child carry a backpack? _____ Approximate weight of backpack:_____

Does your child consume: ☐ Caffeine ☐ Soda ☐ Sugar ☐ Artificial sweeteners ☐ Fast Food ☐ Processed Food

If applicable, has your child experienced menstruation? ☐ Yes ☐ No Age at onset? _____

Medical Information

Name of Pediatrician:_____ Address:_____

Date of last: Physical Exam:_____ X-ray:_____ Blood Test:_____

Please list any current medications: _____

Please list any current supplements:_____

What changes in your child's health or behavior would you like to see? _____

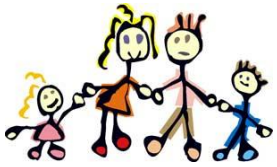
_____

_____

Who is on your health care team to help in cultivating these changes?_____

_____

Doctor's Signature:_____ Date:_____



We are excited to be a part of your child's health care team! We are here to serve you, and we encourage you to ask questions if anything is unclear. Your participation is crucial to your child's health and well-being.
Welcome to our chiropractic family!

AUTHORIZATION FOR CARE OF A MINOR

I HEREBY AUTHORIZE THIS OFFICE AND ITS DOCTORS TO ADMINISTER A CHIROPRACTIC EXAMINATION AND CHIROPRACTIC CARE TO MY SON/DAUGHTER AS THEY DEEM NECESSARY. I DO CLEARLY UNDERSTAND AND AGREE THAT I AM RESPONSIBLE FOR PAYMENT OF ALL FEES CHARGED BY THIS OFFICE.

SIGNED:_____DATE:_____

WITNESS:_____DATE:_____