Franklin Back & Joint Care

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CONFIDENTIAL PEDIATRIC CASE HISTORY

Ages: Newborn-12 years

Dear Patient/Guardian: Your answers will help us to determine if chiropractic can help. If we do not sincerely believe your condition will respond, we will not accept your case.

Name ______________________ Social Security # ______________
Address ______________________ City ____________ St _____ Zip ________
Home Phone ________________ Age ______ Birthdate ________________
Family Doctor/Pediatrician Name (if Known) ______________________

HEALTH INFORMATION:

Have you had previous chiropractic care? ________ When was last adjustment? ____________
What is your Major complaint? ______________________
Other complaints? ______________________
How long have you had your major complaint? ______________________
What aggravates your condition (ex: bending, lifting) ______________________
____
What helps relieve your condition (ex: heat) ______________________
Is this condition getting worse? (circle one) **YES** **NO**
Is the condition **CONSTANT** or does it **COME & GO?** (circle one)
Other doctors who treated this condition ______________________
List surgical operations and year ______________________
____
Medications that you now take ______________________
____
Have you ever had a personal injury: **YES** **NO**
Brief description ______________________

Children ages 5-15 should be checked a few times a year for signs of scoliosis that can be slowed or even corrected. Please tell the doctor when your child was last examined.

PAIN & SYMPTOMATIC DESCRIPTION:

Have you ever suffered from: (circle all that apply)

Dizziness Backaches Heart Trouble Diabetes

Digestive Problems Neck Pain Foot/Ankle/Knee/Hip Problems

PEDIATRIC QUESTIONNAIRE:

Has your child ever had any of the following:

Ear Infections? **Alot** **Some** **None**

Colic? **Yes** **No**

Constipation? **Yes** **No**

Headaches? **Yes** **No**

Scoliosis? **Yes** **No** **Never Checked**

Asthma? **Yes** **No**

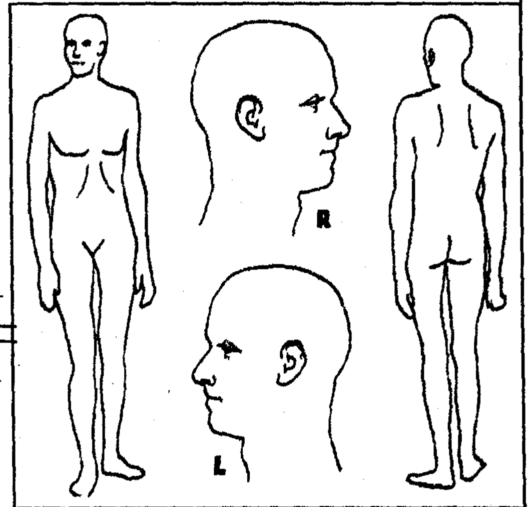
Allergies? **Severe** **Mild** **None**

Birthing Process: **Ceasarian** **Normal** **At Home Birth**

Does Your Child Have Irregular Walking/Running Patterns?

Yes **No** Describe:____________________

Please mark your areas of complaint on the figures below.



INSURANCE INFORMATION:

Is the condition due to an auto accident ? **YES** **NO**

Do you have Health Insurance? **YES** **NO**

If yes, name of company________________________ Policy#____________________

Name and Date of birth of the policyholder being used______________________________

____

Please Read the following statement and sign below:

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Franklin Back & Joint Care will prepare any necessary reports and forms used in making collections or for personal/legal needs. However, I clearly understand and agree that all services rendered me are charged directlt to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care treatment, any fees for professional services rendered me will be immediately due and payable.

Patient Signature____________________________________ Date________________

Guardian or Spouse's Signature____________________________ S.S#________________

Remember: Chiropractic care is meant for the entire family. We'd be happy to schedule spinal exams for your other children for ages newborn - 12. Subluxations can cause asthma, constipation and scoliosis in kids!