



Yost Family Chiropractic

We are honored that you have chosen us to assist you and your family's health & wellness needs. Please let us know if there is any way we can make you and your family more comfortable. We look forward to working with you to build better health for your family.

Pediatric History & Adolescent Form (birth to 16 years)

Patient Name: _____ Nick-Name _____ Today's Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Birth Date: ___/___/___ Sex: _____ Weight: _____ Height: _____

Whom may we thank for referring you to our office? _____

Father's Name: _____ Mother's Name: _____

Father's Cell Phone: _____ Mother's Cell Phone: _____

Home Phone: _____ Email: _____

Parent's marital status (please circle): Single Married Divorced Widowed

In the event we need to contact you, what is the best method of communication for your family? (circle one) Phone E-Mail Text

At our office we are interested in your entire family's health and well-being. Please mention below any health conditions or concerns you may about yourself or the other members of your family:

Yourself/Spouse: _____

Other Children: _____

Others: _____

Purpose for Contacting Us (please circle any) of the following:

Spinal Check-Up Wellness Other

Please Explain: _____

If Applicable: Other Doctors Seen for This Condition: ___ No ___ Yes

Doctor's Name & Prior Treatments: _____

Previous Chiropractor: _____

Date of Last Visit: ___/___/___ Reason: _____

Name of Pediatrician: _____ Date of Last Visit: ___/___/___ Reason: _____

Your Child's Health Profile:

Vaccination History:

(Please check) ___ Up to Date ___ Chose to decline Vaccinations ___ Still Deciding

Please describe any adverse reactions to vaccinations: _____

I would like more information on the adverse reactions and potential dangers of vaccinations ___yes ___no

Please mark an "O" if it is a *Past Condition* or an "X" for a *Present Condition*.

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Ear Infection | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Seizures | <input type="checkbox"/> Chronic Colds |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Asthma | <input type="checkbox"/> Allergies | <input type="checkbox"/> Digestive Problems |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Recurrent Fevers | <input type="checkbox"/> Growing Pains | <input type="checkbox"/> Colic |
| <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Anemia | <input type="checkbox"/> Reflux | <input type="checkbox"/> Behavioral Problems |
| <input type="checkbox"/> Leg Problems | <input type="checkbox"/> Poor Posture | <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Heart Trouble |
| <input type="checkbox"/> Stomach Aches | <input type="checkbox"/> Muscle Pain | <input type="checkbox"/> Orthopedic Problem | <input type="checkbox"/> Neck Problems |
| <input type="checkbox"/> Joint Problems | <input type="checkbox"/> Constipation/diarrhea | <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Arm Problems |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Walking Trouble | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Diabetes |

Other: _____

Number of doses of Antibiotics your child has taken: _____

Please list any drugs or medications (prescription or over the counter) your child is taking: _____

Please list any vitamins/supplements/herbs/homeopathic/other your child is taking: _____

Prenatal History:

Name of Obstetrician/Midwife: _____

Complications during Pregnancy: No Yes List: _____

Medications during Pregnancy/Delivery: No Yes List: _____

Cigarette/Alcohol use during Pregnancy: No Yes List: _____

Location of Birth: Hospital Birthing Center Home

Birth Intervention: Forceps Vacuum Extraction Cesarean Section (emergency or planned?)

Complications during Deliver: No Yes List: _____

Genetic Disorder or Disabilities: No Yes List: _____

Birth Weight: _____ Birth Length: _____ APGAR Scores: _____

Feeding History:

Breastfed: No Yes How long? _____

Formula fed? No Yes How long? _____, which formula? _____

Does the baby prefer feeding on one side than the other? Yes No

Introduced to solids at: _____ Months, Cows Milk at _____ Months.

Food/Juice Allergies, Sensitivities, or Intolerances: Yes No List: _____

Developmental History:

During the following times your child's spine is most vulnerable to stress and should be routinely be checked by a doctor of chiropractic for prevention and early detection of **vertebral subluxation** (spinal nerve interference). At what age was your child able to:

_____ Respond to Sounds _____ Cross Crawl _____ Hold Head Up
_____ Sit Up _____ Stand Alone _____ Walk Alone

Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please (X) the appropriate answer to the following questions with the best of your ability.

Did your child have a traumatic birth? Yes No Unsure
Has your child had any serious falls? Yes No Unsure
Did/Does your child play youth sports? Yes No Unsure
Has your child been involved in a car accident? Yes No Unsure
Has your child been under chiropractic care? Yes No Unsure

On average, how many hours of sleep does your child get per night? _____

Bio-Chemical (Ages 3 and above)

Please write **Never** (0 days), **Rarely** (1-2 days), **Occasionally** (3-5 days), or **Always** (6-7 days) for the statements below. (Questions are based on days/week)

Does your child drink 2-8oz glasses of water? _____
Does your child take a fish oil supplement? _____

Does your child eat 4-8 servings of fruits & vegetables? _____

Does your child splenda, or other artificial sweeteners? _____

Does your child eat fast food? _____

Does your child take medication? _____

Does your child eat processed, packaged, or pre-made foods? _____

Does your child eat sugary snacks, candies, or cereals? _____

Does your child drink soda? _____

Does your child eat white bread or pastas? _____

Bio-Physical (Ages 5 and above)

Please write **Never** (0 days), **Rarely** (1-2 days), **Occasionally** (3-5 days), or **Always** (6-7 days) for the statements below. (Questions are based on days/week)

Does you feel a child book bag is to heavy? _____

Does your child get at least 1 hour of physical activity daily? _____

Lifestyle (Ages 5 and above)

Please write **Never** (0 days), **Rarely** (1-2 days), **Occasionally** (3-5 days), or **Always** (6-7 days) for the statements below. (Questions are based on days/week)

Does your child have difficulty concentrating? _____

Does your child complain of feeling overwhelmed or frustrated? _____

Does your child get angry easily? _____

Does your child feel confident in social settings? _____

Staff Use: Total Score _____

Auto Accident Information

Please mark your involvement in the Auto Accident: Pedestrian Driver Passenger

What are your current symptoms? Pain Numbness Stiffness Weakness

Date of Accident ____/____/____

Patient was located: Driver Passenger- middle front Passenger- right front
 Passenger- left rear Passenger- middle rear Passenger -right rear

Patient Vehicle Type: Compact Mid-size Full-Size SUV Pick-up Motorcycle

Second Vehicle Type: Compact Mid-size Full-Size SUV Pick-up Motorcycle

Third Vehicle Type: Compact Mid-size Full-Size SUV Pick-up Motorcycle

Road Conditions: Clear Dark Dry Foggy Icy Wet

Road Type: Asphalt Concrete Dirt Gravel

Were you aware the accident was going to occur? Yes No

Were you wearing a seatbelt? Yes No

Did your airbag deploy? Yes No

Does your car have a head rest? Yes No

What position was the head rest in? Up Middle Down

Patient's Head Position: Looking Straight Ahead Left Level Left Up Left Down
 Right Level Right Up Right Down Looking Up Looking Down

Accident Details

Was your car braking? Yes No Was your car moving? Yes No
If yes, how fast? (mph) <5 6-10 11-15 16-20 21-30 31-40 41-50 51-60 61-70 >70

Was the second vehicle braking? Yes No Was the second vehicle moving? Yes No
If yes, how fast? (mph) <5 6-10 11-15 16-20 21-30 31-40 41-50 51-60 61-70 >70

Was the third vehicle braking? Yes No Was the third vehicle moving? Yes No
If yes, how fast? (mph) <5 6-10 11-15 16-20 21-30 31-40 41-50 51-60 61-70 >70

Collision Details

First Impact: hit by other vehicle hit other vehicle hit by object hit object
Impact Location: front front-right front-left left
 right right-rear left-rear rear top

Second Impact: hit by other vehicle hit other vehicle hit by object hit object
Impact Location: front front-right front-left left
 right right-rear left-rear rear top

Collision Results

Body was thrown: Forward Backward Left Right Can't Remember

Head Hit: airbag front windshield rearview mirror steering wheel
 dashboard back of the front seat side window/door another person's body headrest

Chest Hit: airbag steering wheel dashboard back of the front seat
 side window/door another person's body

Shoulders Hit: shoulder harness side window/door back of front seat another person's body

Knees Hit: steering wheel dashboard back of the front seat
 door panel center console another person's body

Hips Hit: steering wheel dashboard back of the front seat
 door panel center console another person's body

Vehicle Damage

Patient Vehicle: totaled significant damage light damage no damage
Second Vehicle: totaled significant damage light damage no damage
Third Vehicle: totaled significant damage light damage no damage

Hospitalized

Were you hospitalized? Yes No. If yes, please answer the questions below.

When were you hospitalized? immediately later same day next day date _____

How were you transported to the hospital? ambulance life flight private transportation

What did the hospital recommend? no instructions see this clinic see DC
 see own doctor see orthopedist see neurologist prescription medication
 other: _____

Did you have any xrays taken? Yes No

Are we coordinating care with your physician?:

I would like a copy of NO YES my records sent to my physician

(Circle one) Primary Physician, Pediatrician, Ob/Gyn, Asthmatic specialist, Orthopedic Surgeon, Internist, Other

Dr.'s Name: _____

Clinic's Name & Location _____

Financial Policies:

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Yost Family Chiropractic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Yost Family Chiropractic will be credited to my account upon receipt. I understand that insurance companies do

not pay for services that they determine to be not “medically necessary” and therefore, may deny payment for the services provided to me by Dr. Heather. However, I clearly understand and agree that all services rendered to me are my personal responsibility and I am securing my account with the credit card listed below. I also understand that if I suspend or terminate my care or treatment, any fees for professional services rendered me will be immediately due and payable. If payment hasn’t been received in 10 days from terminating care, I authorize deduction from my credit card.

Please Note: Insurance companies do not pay for care that is not medically-necessary. If your child does not have a musculoskeletal complaint, he/she does not qualify for insurance coverage.

MasterCard/Visa Account # : *Please have available when checking in at front desk if using insurance.*

Informed Consent & Authorization to Treat a Minor:

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by Dr. Yost and/or other licensed doctors of chiropractic who now or in the future work at Yost Family Chiropractic Inc.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. I understand that results are not guaranteed.

I have read the above consent. I understand I have the opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Consent to treat a Minor: _____

Guardian or Spouse’s Signature of Authorizing Care: _____

I acknowledge that I have received the Chiropractic Clinic’s Notice of Privacy Practices for protected health information.

Patient’s Signature: _____ **Date:** _____