Health First Chiropractic Clinic, P.C.
"Caring for Your Health First"

3097 29th St SE
Grand Rapids, MI 49512
Phone: 616-974-9922 Fax: 877-866-2053
www.health1stchiropractic.com

## Pediatric Case History

*The Pediatric Case History is for children **ages 12 and under**. If you are 13 and over, please ask the front desk for the correct paperwork. Thank you.*

Today's Date: _____

Patient Name: _____ Date of Birth: _____
Sex: M F Parent of Guardian: _____

Address: _____ City: _____ State: ___ Zip: _____
Phone Number: _____/Alternate: _____ Type: _____

Insurance Company: _____ *Please give card to staff for a copy.*
Name of *Primary Insured:* _____ Date of Birth: _____
Relation to *Primary Insured:* _____

*In case of emergency, please contact:* _____
Relation to Patient: _____ Phone: _____

## Patient Health

What is the current health problem? _____
How did this happen? _____
When did this happen? _____
Anything make it better or worse? _____
How bad is it (1-10, 10 is worst)? 1 2 3 4 5 6 7 8 9 10

Please circle any of the following conditions that your child has had.

| | | | |
|---|---|---|---|
| Ear Infections | Chronic Colds | Recurring Fevers | Asthma Attacks |
| Digestive Problems | Growing Pains | Colic | Bed Wetting |
| Headaches | Seizures | Allergies* | ADD/ADHD |
| Scoliosis | Back Pain | Croup/Cough | Difficulty Sleeping |
| Strep Throat | Neck Pain | Nose Bleeds | Other: _____ |

Is you child on any prescription or over the counter medications? Yes No
If yes, please name: _____
Has your child received any vaccinations? Yes No
Has your child been involved in any accidents? (School, sports, etc.) Yes No
Has your child fallen from any height? Yes No
If yes, please describe: _____
Has your child been developing normally? Yes No
If no, please describe: _____
Were there any complications in the birth process? Yes No
If yes, please describe: _____

How often does this bother your child?_____

_____

Does anything make it better or worse?_____

Any prior interventions such as MD, DO, prescription meds for this problem? If yes please describe_____

_____

Are there any changes in your child's health since this happened or any other concerns?

_____

_____

_____

_____

List any surgeries? _____

How did you hear about our office? _____

*I authorize use of this form on all my insurance submissions. I authorize release of information to all my Insurance Companies. I understand that I am responsible for knowing my insurance coverage as I will be provided the most appropriate care deemed necessary without consideration or knowledge of my insurance plan. I understand a claim will be submitted to my insurance company as a courtesy. I understand that any services not covered are my responsibility. I understand I am responsible for my bill. I authorize Dr. Szagesh to act as my agent in helping me to obtain payment from my insurance company. I authorize payment directly to Health First Chiropractic Clinic, P.C. I permit a copy of this authorization to be used in place of the original.*

*I acknowledge that Dr. Szagesh of Health First Chiropractic Clinic, P.C. may be adjusting me and discussing my conditions and treatments in a joint adjusting area. If I have any questions, wish to be adjusted, or to discuss my health care in private, I have the option to schedule a time with the doctor in a private consultation or adjusting room.*

*I state that the above information is correct and adequate to the best of my knowledge.*

Printed Patient Name

_____

Printed Patient Representative Name

Relationship to Patient

_____

_____

Patient Representative Signature

Date

_____

_____

Health First Chiropractic Witness

Date

_____

_____

*Implemented 7/5/2016*