For Birth to 12 Years

Date: _____
Child's Name: _____ Date of Birth: _____ SSN: _____
Age of child: _____
Parent/Guardian's Names: Father: _____ Mother:_____
Address: _____ City: _____ State: _____ Zip: _____
Email: _____
Home Phone: _____ Is it ok to leave a detailed message? Y/ N
Cell: _____ Is it ok to leave a detailed message? Y/ N
Work:_____ Is it ok to leave a detailed message? Y/ N
Has your child been seen by a chiropractor before? Y/ N
Has your child had X-Rays taken? Y/ N If yes, what for/ what area? _____
Who is your pediatrician? _____ Location: _____

Prenatal History (Please answer for children under 3)

Birth weight: _____ Birth Length: _____ Born at _____ weeks
Type of Birth: ___Vaginal ___Breech ___Cesarean Where: ___Home___ Birthing Center ___Hospital
Provider: ___Mid- Wife ___OB-Gyn Who: _____
Any medications used during delivery? (including epidural) _____
Was labor induced? Y/ N If yes, why? _____
Any problems during pregnancy and/or labor?_____
Birth Trauma: ___Fractures ___Twisting and/or Pulling ___Vacuum Extraction ___Forceps ___ C-Section
APGAR Scores: _____ (1 min) _____ (5 min)
Jaundice (yellow) at birth? Y/ N Cyanosis (blue)? Y/ N Birth defects/Abnormalities _____
Do you/Did you breastfeed your child? Y/ N If yes, for how long? _____
Does your child prefer to feed on one side over the other? Y/ N Right/ Left
Does your child have any food or other allergies? Y/ N If yes, please list: _____
Has your child been immunized according to the recommended schedule? Y/ N
Did your child have any reactions to vaccinations? Y/ N If yes, what: _____
Were they reported? Y/ No Has your child had any surgeries? Y/ N If yes:_____
Have they been on antibiotics? Y/ N How many times? ____ Reason: _____
Current Medications: _____
Current Vitamins/Supplements: _____

Developmental History At what age did the following occur:

Respond to sound _____ Follow object with eyes _____ Hold head up _____ Crawl _____
Sit alone _____ Stand _____ Walk alone _____ Chicken pox _____ Rubella _____
Rubeola _____ Whooping cough _____ Mumps _____ Measles _____
Other _____

Has the child ever suffered from (please circle all that apply):

Allergies Anemia Arm Problems Arthritis Asthma Backaches Bed Wetting Behavior Problem Blood Disorder Broken Bones Colds/Flu Colic Crying Spells Diabetes Diarrhea Digestive Issues Dizziness Chronic Earaches Fainting Falls "Growing Pains" Headaches Heart Trouble Hyperactivity Joint Problems Leg Problems Low weight Muscle Jerking Neck Problems Numbness/Burning Paralysis Rheumatic Fever Hernia Sinus Trouble Sleeping Problems Stomach Aches Tonsillitis Tuberculosis Walking Problems Other: _____

Relevant family history: _____
What brings your child in today? _____
List any other care your child has undergone with regards to this complaint including medication:
_____
What sports/ activities does your child play/ participate in?_____
How would you rate your child's diet? Well Balanced Average Poor
How much water does your child drink ____ glasses/ day
Does your child consume artificial sweeteners? Y/ N

# of hours your child sleeps: _____ Quality: Good Fair Poor
Is there anything else we should know about your child? _____

Authorization to Treat a Minor
I, _____ parent/ guardian of _____, a minor, do hearby authorize, request and direct Dr. Nixon and whomever she may designate as assistant to perform in judgement any examination and chiropractic diagnosis or treatment which is deemed necessary.

Parent/Guardian Printed Name: _____ Date: _____

Signature: _____

Insurance
Insured's Name: _____ Date of Birth: _____
SS#: _____ Relationship to patient: _____
Insured's Employer: _____
Insurance Company: _____
Policy #: _____ Group #: _____

Assignment and Release: I certify that I, and/or my dependent(s), have coverage with above insurance company and assign directly to Elizabeth Nixon / Back in Motion Chiropractic 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 authorize the use of my signature on all insurance submissions. The above named doctor/facility 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 or the benefits payable for related services.

Parent/Guardian Printed Name: _____ Date: _____

Parent/Guardian Signature _____