# Child's Health History

Westwood Family Chiropractic

## CHILD'S PERSONAL DATA

Today's Date: _____

Name: _____

Age: _____ Date of Birth: _____ Gender: ____ M ____ F

Home Address: _____

City: _____ State: _____ Zip: _____

Names & Ages of Siblings: _____

| Parent A | Parent B |
|---|---|
| Name: _____ | Name: _____ |
| Home phone: (_____) _____ | Home phone: (_____) _____ |
| Cell phone: (_____) _____ | Cell phone: (_____) _____ |
| Employer: _____ | Employer: _____ |
| E-mail: _____ | E-mail: _____ |

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

## REASON FOR SEEKING CHIROPRACTIC CARE

What concerns do you feel Westwood Family Chiropractic can address for your child?

_____

Please indicate below how these concerns are affecting your child's quality of life. *(Circle all that apply)*

| | | |
|---|---|---|
| School | Exercise/Sports | Walking |
| Playing | Sleep | Attention/Focus |
| Communication | Eating | Daily Routine |

Other: _____

## HEALTH CARE PRACTITIONER HISTORY

Has your child ever received chiropractic care? ❑ Y ❑ N

Name of D.C. _____

Reason _____

How long? _____ Date of last visit _____

Why was care stopped _____

Have you consulted or do you regularly consult any of the following providers for your child?

Check all that apply ❑ Medical Physician ❑ Naturopath ❑ Acupuncturist ❑ Homeopath
❑ Massage Therapist ❑ Psychotherapist ❑ Energy Healer ❑ Other

Reason: _____

# Health, Vitality and Chiropractic Care

The primary system in the body which coordinates health is the nerve system. The vertebrae, bones of the spinal column, surround and protect the delicate nerve system. Injury to the spine and nerve system is a condition called vertebral subluxation. Vertebral subluxation results in nerve malfunction due to vertebral/spinal misalignment. Vertebral subluxations can have physical, emotional, and chemical causes and effects.

The information below helps the chiropractor see the types of PHYSICAL, CHEMICAL & EMOTIONAL stresses your child has been subjected to; how they may relate to his/her present spinal, nerve and health status and whether they may have played a part in creating vertebral subluxations.

## PREGNANCY & BIRTH

The birth process can be traumatic to a baby's spine and cause interference to the nervous system

During pregnancy did the mother:

Experience any illnesses, difficulties, or trauma? ❑Y ❑ N List:_____

Take any drugs/medications? ❑Y ❑ N List: _____

Smoke or consume alcohol? ❑Y ❑ N List: _____

Was the delivery premature? ❑Y ❑ N Weeks: _____Weight: _____

Approximately how long did labor last? _____ hours

Was labor artificially induced? ❑Y ❑ N

Was the child in a breech position (butt down) or otherwise mispositioned? ❑Y ❑ N

Please check where the child was born & if any of the following were administered during labor and birth.

❑ Home birth ❑ Hospital birth ❑ Vaginal ❑ Water birth ❑ Caesarean
❑ Epidural ❑ Forceps ❑ Vacuum ❑ Medications _____
❑ Pitocin ❑ Episiotomy ❑ Manual traction of the neck

Please check all that apply to the child's status immediately after birth: APGAR Score _____

❑ Jaundice ❑ Respiratory problems ❑ Broken bones:
❑ Feeding problem ❑ Displaced joints ❑ Other conditions:

Was the baby breastfed? ❑Y ❑ N For how long? _____.

## PHYSICAL STRESS: INFANCY & CHILDHOOD

Please check all that apply to your child and give any necessary details:

❑ Uncoordinated/Accident prone
❑ Has been hospitalized
❑ Had a severe trauma or concussion
❑ Been in an automobile accident
❑ Has fractured a bone or dislocated a joint.
❑ Has/had a chronic illness.
❑ Has had surgery.

What physical activities does your child participate in?

## CHEMICAL STRESS

Chemical stresses can occur when a substance that is toxic to the body is breathed, injected, taken by mouth, or comes into contact with the skin. The following will reveal exposures your child may have experienced.

Have you chosen to vaccinate your child? ❑Y ❑ N

If yes, please check all vaccinations the child has received and at what age they were administered:

❑ DPT _____ ❑ Hepatitis _____ ❑ Chicken Pox _____
❑ Polio _____ ❑ MMR _____ ❑ Flu _____
Other _____

Please describe any and all reactions to vaccine(s)

Please check all that apply and give any necessary details:

❑ Child exposed to second hand smoke.
❑ Has taken antibiotics. *Explain:* _____
❑ Currently taking medication. *Explain:* _____
❑ Currently taking supplements. *Explain:* _____
❑ Has allergies. *Explain:* _____
What treatments have you used? _____

## EMOTIONAL STRESS

It is difficult to separate the emotional stress in our life from the physical response that often occurs. Please indicate if your child has ever or is currently experiencing any of the emotional stresses below: *(check all that apply)*

❑ Academic pressure ❑ Loss of a loved one ❑ Bullying ❑ Relocation
❑ Lifestyle change ❑ Parents' divorce ❑ Loss of a pet ❑ New sibling

Does your child have difficulty interacting with schoolmates or friends? ❑Y ❑ N

Have you or anyone else noticed that your child is nervous, twitches, shakes, or exhibits rocking behavior?

❑Y ❑ N

## YOUR EXPECTATIONS FROM CHIROPRACTIC CARE

I would like my child to experience the following benefits from Chiropractic Care: *(Check all that apply)*

❒ Symptomatic relief of a problem
❒ Prevention of future problems
❒ Healthier spine and nerve system
❒ Optimal health on all level
❒ Other _____

*Thank you for choosing Westwood Family Chiropractic!*

Dr. Peter Kevorkian | Dr. Patti Giuliano
781.769.2500 | 1446 High Street | Westwood MA, 02090

# Finances

Westwood Family Chiropractic

## Payment in full is expected on all FIRST VISIT services.

First Visit Fees: Comprehensive Exam: $100 X-Rays (if necessary): $175

Please indicate your method of payment. ❑ Cash ❑ Check ❑ Credit Card

## Our Unique Approach to Finances at WFC

Our patients pay for care "out of pocket" because insurance plans DO NOT COVER corrective or wellness care. We utilize uniquely designed, discounted cash plans to allow you to receive all the care necessary (as determined by your chiropractic evaluation at affordable fees.

## Insurance

If you determine that your insurance plan will reimburse you for chiropractic care in our office, we will provide you with *itemized monthly statements for you to submit.* Please indicate below the type of statement you may need.

- ❑ Flex Plan or Health Savings Account Statement
- ❑ Insurance Statement

## Are you consulting us for an Auto Accident Related Injury?

If yes, please provide us with the following information:

Date of Injury: _____ Has your child been treated for injuries? ❑Y ❑ N

If yes, where? ❑ Emergency Room ❑ Primary Care ❑ Other

What services were provided? ❑ MRI ❑ X-Rays ❑ Medication ❑ Therapy

*NOTE: You will be required to pay for all services until we receive approval and payment from the insurance carrier. Once payment is received you will be reimbursed accordingly.*

The information I have provided on this case history form is true and accurate to the best of my knowledge. I give the doctors at WFC permission to render care to my child today. This initial visit includes a health history consultation, chiropractic exam and evaluation, and any initial care that is determined to be clinically necessary and mutually agreed upon.

Child's Name: (printed) _____

Parent or Legal Guardian's Name: (printed) _____

Signature: _____ Date: _____

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# Consent Form

Westwood Family Chiropractic

## PLEASE READ AND SIGN

1. I have been informed that a copy of Westwood Family Chiropractic's "Notice of Privacy Practices for Protected Health Information (HIPAA)" brochure is available for my review both in the office and on the website at www.westwoodfamilychiropractic.com.

2. I understand that most care is given in an open setting. Private rooms are available upon request.

3. I consent to receive communication from WFC via email, postal mail, text and telephone messaging in connection with my child's care. If I should withdraw my consent, I will notify the office in writing.

4. I consent to my child's name (first name, last initial) being posted on the Referral Board when I refer a new patient to WFC. If I should withdraw my consent, I will notify the office in writing.

5. I consent to my child's testimonial being used in office and electronically with my first name and last initial only. If I should withdraw my consent, I will notify the office in writing.

6. I consent to my and my child's photo or image being used in photograph or video in public media including social media, website, promotional materials. If I should withdraw my consent, I will notify the office in writing.

7. I agree that I am responsible to pay for all services my child receives in this office.

8. I consent to using my name to send a thank you to the referral I listed on page 1.

Name: (printed) _____ Date: _____

Parent or Legal Guardian's Name: (printed)_____

Signature: _____

Please note below any withdrawal of consent to any of the above statements:

Signature: _____ Date: _____

*Welcome to Westwood Family Chiropractic!*

Dr. Peter Kevorkian | Dr. Patti Giuliano

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