

# ABOUT THE PATIENT-PEDIATRIC

Wave Chiropractic, 5233 4<sup>th</sup> Avenue Circle E, Bradenton, FL 34208

Name \_\_\_\_\_ Today's Date \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Gender  M  F  
 e-Mail Address \_\_\_\_\_ Have you been to a chiropractor before?  No  Yes  
 Emergency Contact \_\_\_\_\_ ph # \_\_\_\_\_

Name of Medical Doctor(s) \_\_\_\_\_ How did you hear about us? \_\_\_\_\_

- I authorize the doctor or his staff to render care as deemed appropriate for me and / or my child.
- I authorize Wave Chiropractic to release and / or request records to or from other providers as may be necessary.
- I understand I am responsible for all bills incurred in this office.
- I authorize assignment of my insurance benefits (if applicable) directly to the provider.
- I understand that after any initial promotional services all care is rendered at usual and customary fees.
- For my balance my preferred payment method is:  Cash  Check  Credit Card  Car/Work Ins.

\_\_\_\_\_  
 Patient / Parent Signature (This represents a long term authorization for all occasions of service) Date

## REASON FOR SEEKING CARE

**PRESENT COMPLAINTS**

1. \_\_\_\_\_ How long has this been an issue? \_\_\_\_\_  
 Is it:  Dull  Sharp  Ache  Numb / Tingle  Stabbing  Constant  Occasional  Staying the same  Getting worse  
 Mild  Moderate  Severe  Worse in the morning  Worse in evening  Pain radiates to \_\_\_\_\_

2. \_\_\_\_\_ How long has this been an issue? \_\_\_\_\_  
 Is it:  Dull  Sharp  Ache  Numb / Tingle  Stabbing  Constant  Occasional  Staying the same  Getting worse  
 Mild  Moderate  Severe  Worse in the morning  Worse in evening  Pain radiates to \_\_\_\_\_

3. \_\_\_\_\_ How long has this been an issue? \_\_\_\_\_  
 Is it:  Dull  Sharp  Ache  Numb / Tingle  Stabbing  Constant  Occasional  Staying the same  Getting worse  
 Mild  Moderate  Severe  Worse in the morning  Worse in evening  Pain radiates to \_\_\_\_\_

4. \_\_\_\_\_ How long has this been an issue? \_\_\_\_\_  
 Is it:  Dull  Sharp  Ache  Numb / Tingle  Stabbing  Constant  Occasional  Staying the same  Getting worse  
 Mild  Moderate  Severe  Worse in the morning  Worse in evening  Pain radiates to \_\_\_\_\_

5. Does your condition affect:  Sleep  Work  Daily Routine  Sitting  Driving  
 \_\_\_\_\_

6. What makes it better? \_\_\_\_\_

7. What makes it worse? \_\_\_\_\_

8. What Doctor's have you seen for this? \_\_\_\_\_

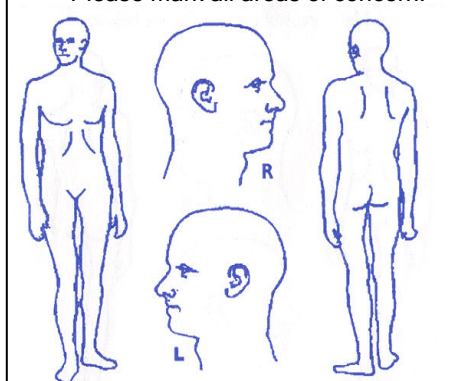
9. Type of treatment: \_\_\_\_\_

10. Results: \_\_\_\_\_

NOTES: \_\_\_\_\_

Are you pregnant?  
 Yes  No

Please mark all areas of concern.



# GENERAL HEALTH HISTORY

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Patient Name \_\_\_\_\_ Mark the conditions that apply to you.

Past Present

- Headaches
- Ear Infections
- Colic
- Allergies / Asthma
- Medication Side Effects
- Recurring Fevers
- Digestive problems
- Bed Wetting
- Chronic Colds/Sinus
- Other \_\_\_\_\_

Past Present

- Vision Problems
- Sleeping Problems
- Growing Pains
- Dental Problems
- Temper Tantrums
- ADHD
- Seizures
- Scoliosis
- Ever Needed Stitches

1. List any medications being taken: \_\_\_\_\_
2. Number of courses of Antibiotics child has taken in the last 6 mo. \_\_\_\_\_ Total during lifetime \_\_\_\_\_
3. Name of Pediatrician and Other Doctors: \_\_\_\_\_
4. Date of Last Visit \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Reason: \_\_\_\_\_
5. Name of Obstetrician/Midwife: \_\_\_\_\_
6. Location of Birth:  Hospital  Birthing Center  Home
7. Complications During Pregnancy:  No  Yes Explain: \_\_\_\_\_
8. Ultrasounds During Pregnancy:  No  Yes How Many: \_\_\_\_\_
9. Medication During Pregnancy / Delivery  No  Yes List: \_\_\_\_\_
10. Cigarette / Alcohol Use during Pregnancy:  No  Yes
11. Has any Doctor / Other Professional advised you to "Take the child to a Chiropractor ":  No  Yes, Name \_\_\_\_\_

## PAST HISTORY

12. List any past auto collisions: \_\_\_\_\_ Was any care received? \_\_\_\_\_
13. List any past falls bumps bruises: \_\_\_\_\_ Was any care received? \_\_\_\_\_
14. List any past sport, recreational, or home injuries: \_\_\_\_\_
15. Please describe any past conditions and treatment received: \_\_\_\_\_  
\_\_\_\_\_
16. Please list any past hospitalizations and surgeries: \_\_\_\_\_  
\_\_\_\_\_

## FAMILY HISTORY

- Father's side:  Heart Disease  Cancer  Diabetes  Heavy Medication use  Arthritis  Other \_\_\_\_\_
- Mother's side:  Heart Disease  Cancer  Diabetes  Heavy Medication use  Arthritis  Other \_\_\_\_\_
- Is there any other family history you want us to know? \_\_\_\_\_