Great Lakes Chiropractic
116 Central Ave East St. Michael, MN 55376
PH: 763-515-6650 | FAX: 763-777-9186

Pediatric Health History
Updated: 06/2023

Date: _____ Patient's Name: _____ Birth Date: _____

Age: ____ Grade: _____ Sex: _____ SS # of Guardian: _____ Mother/Father

Address: _____ City: _____State: _____ Zip: _____

Parent/Guardian 1

Name_____ Email_____

Address, if different_____

Occupation_____ Employer/City_____

Home Phone _____ Cell Phone _____ Work Phone_____

Parent/Guardian 2

Name_____ Email_____

Address, if different_____

Occupation_____ Employer_____

Home Phone _____ Cell Phone _____ Work Phone_____

Send Text Reminders to this Phone #: _____ ☐ No appt. reminders

Number of Siblings_____ Names and Ages_____

_____

Family Medical Doctor_____

Has child received previous chiropractic care? Yes or No

If yes, when was the last adjustment: _____Where?_____

How were you referred to our office?_____

HISTORY OF PRESENT ILLNESS:

Reason for your visit today? _____

How long has your child had this problem? _____

What caused it? _____

Have they ever had the same or a similar condition? Yes or No. If yes, when and describe: _____

_____

HEALTH HISTORY:

Has your child ever experienced the following or been diagnosed as having any of the following:

___ Illness accompanied by a high fever
___ Headaches (occasional or frequent)
___ Seizures/Convulsions
___ Ear infections/earaches (if so, how many) _____
___ Head injury
___ Serious fall or repetitive falls
___ Epilepsy
___ Meningitis
___ Allergies to foods
___ Environmental allergies
___ Chemical insensitivities
___ Is child vaccinated?
___ Have you declined any vaccines?
___ Adverse reaction to any vaccinations (even if mild
If yes, please explain: _____

___ Dizziness
___ Diabetes
___ Hypoglycemia (low blood sugar)
___ Trouble with bladder control
___ Fainting
___ High/Low blood pressure
___ Heart Disease
___ Asthma
___ Sinus problems
___ Constipation
___ Digestive disorders
___ Rheumatic Fever
___ Neck or back problems
___ Joint or muscle problems

NEUROLOGICAL/OTHER:

Has your child ever been diagnosed by a medical professional with any of the following, if yes, by whom:

___ Hearing loss or impairment
___ Neurological disorders
___ Obsessive Compulsive Disorder (OCD)
___ ADD/ADHD
___ Dyslexia
___ Visual impairment
___ Anxiety/Depression
___ Autism/Autism Spectrum Disorder
___ Tourette's Syndrome
___ Other_____

CURRENT/PAST MEDICATIONS AND TREATMENTS:

List any SURGERIES that your child has had_____

List any MEDICATIONS that your child is taking or has taken in the past. Names, dosage, frequency.

_____

_____

List any NUTRITIONAL SUPPLEMENTS your child takes (vitamins, herbs, naturopathic remedies, etc.) _____

_____

List any special services that your child is currently receiving at school or privately_____

List any special needs your child has_____

List any treatment that your child is currently undergoing with any health professional_____

_____

FAMILY HISTORY:

List any health conditions of mother/father_____

_____

ACTIVITIES:

What activities/sports does your child participate in_____

Frequency_____

**** THIS PAGE FOR CHILDREN AGES 0 – 12 ONLY ****

Pregnancy History (Mother)

(If the child is adopted, answer to the best of your ability)
Did you ever experience any of the following during your pregnancy?

___ Severe viral infection during the first trimester
___ Breech position during pregnancy
___ Accident or infections
___ Smoking
___ Severe stress
___ Pre-eclampsia
___ Alcohol consumption and/or drug use
___ Radiation exposure
___ Hypertension (high blood pressure)
___ Toxoplasmosis
___ Uncontrolled Diabetes
___ Toxemia

Labor and Delivery History

Did you and/or the child experience any of the following during the labor/delivery:

___ Hospital birth
___ Long and/or difficult labor
___ Placenta Previa
___ Forceps or vacuum
___ Fetal distress
___ Elective C-section
___ The child was a "blue baby"
___ Home birth
___ The delivery was rapid
___ Breech birth
___ Cord around neck
___ Emergency C-section
___ The child was premature (2+ weeks)

___ Labor was induced. If yes, reason? _____
___ Medications during delivery. If yes, list (i.e. Epidural) _____
Comments: _____
_____

Newborn History

Weight at birth: _____ Length at birth: _____
Did the child experience any of the following as a newborn?

___ Required resuscitation/oxygen
___ Jaundice
___ Poor sleeper
___ Colic
___ Immunizations in hospital
If yes, specify vaccine: _____
___ Distorted skull
___ Difficulty latching/sucking
___ Formula fed
___ Feeding (___ breast or ___ bottle)
If breast fed, how long _____

Developmental History

Does your child have any of the following?

___ Difficulty with crawling (on all fours)
___ Difficulty learning to ride a bike
___ Difficulty learning to read
___ Difficulty using utensils
___ Difficulty tying shoes
___ Poor hand-eye coordination
___ Did not crawl on all fours
___ Appears clumsy
___ Difficulty with writing
___ Difficulty buttoning clothing
___ Difficulty or awkward with walking/running
___ Difficulty sitting still or paying attention

Age of child when he/she sat _____ crawled _____
How long did your child crawl (in months): _____
At what age did your child start to walk unassisted: _____

AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize the doctors at Great Lakes Chiropractic to evaluate and treat my son/daughter as she deems necessary.

I understand and agrees to allow Great Lakes Chiropractic to use Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

_____ _____

SIGNATURE OF PARENT OR GUARDIAN AUTHORIZING CARE **DATE**

_____ _____

WITNESS **DATE**

STANDARD CONSENT

When a patient seeks Chiropractic health care, and we accept a patient for such care, it is essential for both doctor and patient to be working towards the same objective. Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxations. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a Chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for these findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. Our only practice objective is to eliminate a major interference to the expression of the body's natural ability toward self-healing. Our only method is specific adjusting to correct vertebral subluxations.

Any procedure intended to help may also do harm. While chiropractic procedures done in this office are usually considered remarkably safe and effective, please understand there are occasional and rare complications which have been documented. While the chances of experiencing these complications are extremely small, it is the practice of this office to fully inform and educate all of our patients about them. Cervical manipulations have rarely caused injuries to the small blood vessels that go to and from the upper neck to the brain. The risk of this occurring is thought to be one in three million to one in fourteen million, according to several studies. These other complications include but are not limited to:

pain	burns	swelling	sensory changes
soft tissue injury	bruising	bleeding	stroke(CVA)
discoloration	fracture	dizziness	inflammation
disc injury	nausea	weakness	soreness

By signing below, I understand that there is no guarantee or warranty of a specific cure or result. I understand that I can request specific additional information from the doctor regarding treatment risk. Given this information, I consent to care.

_____ _____

SIGNATURE OF PARENT OR GUARDIAN **DATE**

FINANCIAL POLICY

INSURANCE: You should be prepared to present your current insurance card. All claims will be submitted to your insurance carrier unless otherwise specified. We do not have a way to access the terms of your insurance policy and therefore cannot quote coverage or benefit levels or guarantee that your insurance company will cover the services we have provided. If you have questions, please call your insurance carrier directly.
I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Great Lakes 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 Great Lakes Chiropractic will be credited to my account. However, I agree that I am personally responsible for all services not paid for by my insurance. I am also responsible for any annual deductibles applicable, copayments, or non-covered services as may be required by my insurance plan. I also understand that if I suspend or terminate, any fees for professional services rendered to me will be immediately due and payable.

Insurance Policy Holder's First and Last Name: _____DOB: _____
Relationship to patient: _____

COPAYS: Co-payments are due on the day of your appointment.

SECONDARY/SUPPLEMENTAL INSURANCE: Please inform us of any secondary insurance you may have.

MEDICARE: We do accept Medicare. Medicare covers manual manipulation of the spine *only.* All other services are NOT covered. These services include, but are not limited to: x-rays, examinations and therapies. You are required to pay any deductible and remaining balance after Medicare processes your claim.

WORKER'S COMPENSATION/PERSONAL INJURY: Please inform us immediately if you are injured on the job or are involved in an accident. We will work with you to manage your care and submit your fees.

SELF-PAY RATE/NO INSURANCE: For patients who carry insurance in which we are not in-network or for patients who do not wish to submit claims to their insurance company, we offer a self-pay office visit. If this is something you may be interested in, please ask at the front desk. This charge will be due at the time of your appointment.

STATEMENTS: After your insurance company has processed your claims, you will receive a statement from us for the unpaid balance. Your payment is due within 30 days of the statement date. If you are unable to pay your balance in full prior to the due date, please call our billing office at 763-777-9313 to set up payment arrangements. ***Late Fees may be charged to your account if timely payment is not made.***

MISSED APPOINTMENT POLICY: Your time is important, as is ours. If you must cancel or reschedule an appointment, please make every effort to do so at least 24 hours prior to your appointment time. ***If you do not call to cancel/reschedule and you do not come in for your appointment, a $40.00 fee will be charged to your account.***

I have read and understand the Financial Policy of Great Lakes Chiropractic. I understand that I am responsible for all services not paid for by my insurance including deductibles, copayments, or non-covered services. I am also responsible for any fees incurred if incorrect insurance information is provided or not updated in a timely manner.

_____ _____
SIGNATURE OF PARENT OR GUARDIAN **DATE**

Authorized people who have access to my information

I authorize Great Lakes Chiropractic to share my account information including TREATMENT DETAILS, ACCOUNT INFORMATION, PAYMENT DETAILS, AND APPOINTMENT TIMES with the following people. (ex: spouse, parent, children)

Name: _____

Relationship to patient: _____

Name: _____

Relationship to patient: _____

Name: _____

Relationship to patient: _____

This is valid until revoked or changed by written communication.

_____ _____
SIGNATURE OF PARENT OR GUARDIAN **DATE**

~~~~~~

CONSENT TO TREAT A MINOR WITHOUT PARENT/GUARDIAN PRESENT

By law, any child under the age of 18 years old cannot be seen by a doctor without consent from a parent or legal guardian. I authorize Great Lakes Chiropractic and its personnel to administer chiropractic care as deemed necessary to:

_____ _____
NAME OF MINOR **DATE OF BIRTH**

_____ _____
PARENT OR GUARDIAN (Please Print) **DATE**

_____
PARENT OR GUARDIAN SIGNATURE
~~~~~~