

# PEDIATRIC PATIENT INFORMATION

(4-17)

PATIENT NAME Birth date.: SEX

(Medicare/Medicaid only) S.S #: - -

MOTHER’S NAME FATHER’S NAME

ADDRESS CITY STATE ZIP

HOME PHONE CELL PHONE

FAMILY EMAIL

REASON FOR OFFICE VISIT:

WHEN DID THIS BEGIN?

HOW DID THIS HAPPEN/WHAT WERE YOU DOING?

IF PAIN, DESCRIBE (CIRCLE): SHARP, DULL/ACHY, VARRYING, TRAVELS, CONSTANT

RATE THE PAIN 0-10, WITH 0 BEING NO PAIN AND 10 BEING THE WORST PAIN YOU COULD IMAGINE:

SINCE THE PROBLEM STARTED, IS IT: (CIRCLE) ABOUT THE SAME, GETTING BETTER, GETTING WORSE

WHAT MAKES IT WORSE: BETTER:

IT INTERFERES WITH: (CIRCLE) WORK/SCHOOL, SLEEP, WALKING, HOBBIES/SPORTS, OTHER:

OTHER DOCTORS SEEN FOR THIS PROBLEM:

TREATMENT(S) RENDERED? OUTCOME?

HAVE YOU HAD X-RAYS, MRI, OR A CT?

CURRENT HEALTH PROBLEMS/CONCERNS:

MEDICATIONS:

CURRENT SUPPLEMENTS:

MAJOR HOSPITALIZATIONS/SURGERIES/INJURIES, (INCLUDE YEAR AND OUTCOME)

HAS THE PATIENT HAD ANY MAJOR FALLS SINCE BIRTH? STICHES OR A FRACTURE?

ANY CAR ACCIDENTS? TYPE OF ACCIDENT? WAS ANYONE INJURED?

## PLEASE CHECK ALL THAT APPLY:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  WEAKNESS |  | EARACHES |  | HEAD INJURY |  HEADACHES |
|  COUGH |  | ASTHMA |  | DIZZINESS |  |
|  FAINTING |  | SEIZURES |  | CONSTIPATION |  DIARRHEA |

**HEALTH HABITS (PER DAY)**

EXERCISE/SPORTS:  5-7 DAYS/WK  3-4 DAYS/WK  1-2 DAYS/WK  NONE

TYPE: HOURS PER SESSION:

WEIGHT OF SCHOOL BACKPACK

…………………………………………………………………………………………………………………

# AUTHORIZATION FOR CARE OF MINOR

I HEREBY AUTHORIZE THIS OFFICE AND ITS DOCTOR TO ADMINISTER CARE AS THEY SO DEEM NECESSARY TO MY SON/DAUGHTER/WARD (UPON APPROVAL OF PARENT OR GUARDIAN)

SIGNED: RELATIONSHIP: DATE:

Electronic Health Records Intake Form

*In compliance with requirements for the government EHR incentive program*

|  |  |
| --- | --- |
| **First Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Last Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Email address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_@\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DOB:**  \_\_/\_\_/\_\_\_**Gender (Circle one):**  Male / Female **Preferred Language: \_\_\_\_\_\_\_\_\_\_\_\_\_**

***Smoking Status (Circle one*):** Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

*CMS requires providers to report both race and ethnicity*

***Race (Circle one):*** American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / Other / I Decline to Answer

***Ethnicity (Circle one):***Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

**Are you currently taking any medications?**

(Please include regularly used over the counter medications)

|  |  |
| --- | --- |
| Medication Name | Dosage and Frequency (i.e. 5mg once a day, etc.) |
|  |  |
|  |  |
|  |  |

**Do you have any medication allergies?**

|  |  |  |  |
| --- | --- | --- | --- |
| Medication Name | Reaction | Onset Date | Additional Comments |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Check this box if you choose to decline receipt of your clinical summary after every visit**

*(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| Height: \_\_\_\_\_\_\_\_\_ Weight:\_\_\_\_\_\_\_\_\_\_\_\_ Blood Pressure:\_\_\_\_\_\_ /\_\_\_\_\_\_ HR\_\_\_\_\_\_\_ |