ADVANCED PHYSICAL HEALTH

CHIROPRACTIC

Columbia, Missouri

PEDIATRIC HISTORY FORM

We welcome you and your family to our clinic, Advanced Physical Health. In order to help us better serve you, please complete the following information. We look forward to working with you to build better health for your family.

Child's Name: _____ Today's Date: _____

Birth Date: ____/____/____ Age: _____ Female/Male (Circle One)

S/S #: _____

Whom may we thank for referring? _____

Primary Guardian's Information

Name: _____ Relationship: _____

Cell Phone Number: _____ Secondary Number: _____

Email: _____

Address: _____ City: _____ State: _____ Zip: _____

Occupation & Employer: _____

If you wish for us to submit to insurance, please present your card to the front desk staff member.

Child's Current Health History

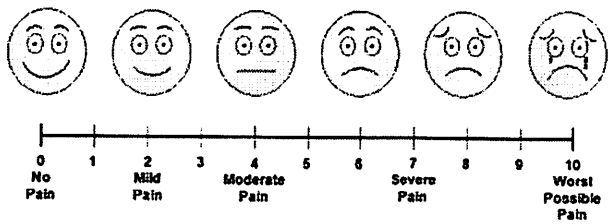
Reason(s) for care:

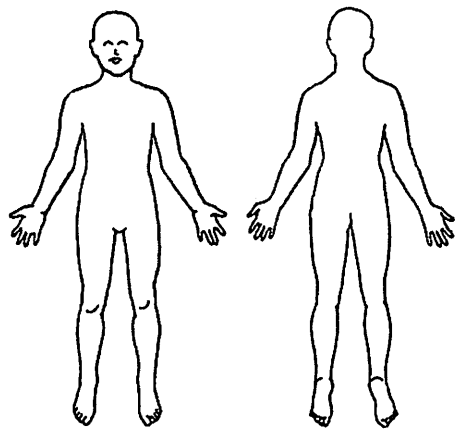
☐ Maintenance ☐ Improved Health ☐ Problem: _____

When did the symptoms appear: _____

Is the condition getting progressively worse? **Y/N**

Please mark an X on the picture for the area of involvement. Please circle the number along the scale that best describes the pain.





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Please check any of the following conditions that apply:

____ADD/ADHD	____Allergies	____Asthma	____Growing Pains
____Bed Wetting	____Chronic Colds	____Colic	____Autism
____Digestive Problems	____Ear Infections	____Headaches	____Seizures
____Recurring Fevers	____Reflux	____Scoliosis	

Other doctors seen for this condition (please include doctor's name, tests done and prior treatments):

_____

_____

_____

Current: Weight _____lbs. Height _____ft. _____in.

Developmental History:

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (bed, changing station, etc).

Did your child have a fall similar to what was described: **Y/N**
If yes please describe: _____

Have there been any other traumas? **Y/N**
Pleas list any injuries or accidents: _____
Date(s) of occurrence: _____

Has your child been involved in any sports? **Y/N**
Which sports: _____

Name of Pediatrician and last visit: _____
Has your child been seen by a physician on an emergency basis? **Y/N**

Number of doses of antibiotics your child has taken in the...
Past 6 months: _____Total Lifetime: _____

Present prescription drugs/dosage: _____
Past prescription drugs/dosage: _____
Over the counter drugs (Tylenol, cough syrup, laxatives, etc.) _____

Family history of significant spinal conditions:

_____

_____

_____

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CHILDREN'S CONSENT

By signing below, I hereby request and give my consent for any physical examination, evaluation and the performance of procedures needed. The treatment many include chiropractic spinal manipulation and other physiotherapy modalities as necessary. I wish to rely on the doctors of Advanced Physical Health, PC to make those decisions about my care, based on the facts then known that she believes to be in my best interest. If the patient is a minor, by signing, I give consent for examination, testing and procedures for the minor.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my physician. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility. I have had an opportunity to discuss with the doctors of Advanced Physical Health, PC the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I authorize Advanced Physical Health, PC to release medical records required as is necessary. I understand that by signing below I give written consent for the use and disclosure of protected health information for treatment and health care operations.

Child's Name: _____ **Date:** _____

Parent/Guardian name: _____ **Signature:** _____

ADVANCED PHYSICAL HEALTH
1511 Chapel Hill Road
Columbia, MO 65203

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name:_____ **Last Name:**_____

Email'address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

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

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: _____ Date:_____

For office use only

Height: _____ Weight:_____ Blood Pressure:_____/_____