WELCOME

ROCK COUNTY CHIROPRACTIC

Dr. Michael P. Smith, DC
103 E Main, Luverne, MN 56156
(507) 283-2561 PH (507) 283-1831 FAX

PEDIATRIC PATIENT INFORMATION

Patient Name_____Date_____

Sex ¶ M ¶ F Age____ Birth Date_____

Address_____

_____

Mother_____

Occupation_____ Phone_____

Father_____

Occupation_____ Phone_____

Siblings_____

_____

_____

INSURANCE

Who is responsible for this account?_____

Relationship to patient_____

Insurance Co._____

Group #_____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr._____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____
Responsible Party Signature

_____ _____
Relationship Date

FAMILY MEDICAL HISTORY

Please check if any blood relatives to the patient had any of the following illnesses and mark accordingly by noting M (Mother); F (Father); S (Sibling); PGM (Paternal Grandmother); MGM (Maternal Grandmother); PGF (Paternal Grandfather); or MGF (Maternal Grandfather).

_____Allergy, Asthma, or Eczema _____Heart Trouble _____Mental Illness

_____Cancer _____Kidney Disease _____Scoliosis

_____Diabetes of Low Blood Sugar _____Liver Disease _____Ulcers

_____High Blood Pressure/Stroke _____Mental Retardation _____Other_____

PREGNANCY

Please check any areas that applied to the patient's mother during her pregnancy:

¶ Complications ¶ Medications ¶ Recreational drugs ¶ Smoking ¶ Alcohol ¶ Vitamins/Minerals
¶ Hospitalization ¶ Immunization ¶ Bleeding ¶ Back Pain ¶ Toxic Exposure ¶ Caffeine
¶ Other Pain ¶ Allergic Reactions ¶ Mental Trauma ¶ Physical Injury ¶ Depression ¶ Mostly happy attitude
¶ Excessive Weight Loss ¶ Excessive Weight Gain ¶ Prenatal Classes/Care ¶ Chiropractic Care
¶ Premature Contractions ¶ Carried to Full Term

LABOR AND DELIVERY

¶ Greater than 12 hours ¶ Complications ¶ Caesarian ¶ Hospital ¶ Forceps ¶ Medications ¶ Home Birth
¶ Fetal monitor used ¶ Premature Delivery ¶ Vacuum Extraction ¶ Other _____

PRENATAL HISTORY—if known please indicate

Duration of pregnancy_____ Length at birth_____ Birth weight_____

Apgar score at birth_____ Apgar score at 5 minutes_____

Please check any problems the patient had at birth:
¶ Breathing ¶ Coloring ¶ Crying ¶ Choking ¶ Nursing ¶ Sleeping ¶ Jaundice
¶ Other_____

Please check if any item(s) applied to the patient at birth:
¶ Medication ¶ Artificial Feeding ¶ Vitamin K ¶ Surgery ¶ Erythromyocin ¶ Circumcision
¶ Other_____

NUTRITION

Please check if the patient has received any of the following items:

¶ Breast Milk ¶ Commercial Formula ¶ Cow's Milk ¶ Goat's Milk ¶ Solid Foods ¶ Sweets ¶ Juice: Fruit

¶ Juice: Vegetable ¶ Vitamins ¶ Medications ¶ Other_____

IMMUNIZATION

Please list any immunizations the patient has received along with the date it was received and any reactions observed:

_____ Date_____

_____ Date_____

_____ Date_____

ILLNESSES

Please list any illness(es) the patient has had along with the date(s) of the illness(es) and any treatments received:

_____ Date_____

_____ Date_____

_____ Date_____

FAMILY PHYSICIAN

Pediatrician_____ Date of last examination_____

GENERAL SYSTEM REVIEW

Please check if you child has experienced any of the following:

¶ Unconsciousness or convulsions ¶ Eye/vision problems ¶ Cyanosis (turned blue) ¶ Abnormal stools, consistency or smell

¶ Recurring vomiting or stomach pain ¶ Recurring diarrhea or constipation ¶ Unusual urine frequency, smell, appearance

¶ Back pain, arm pain, or leg pain ¶ Allergies ¶ Eczema ¶ Hay fever, hives

¶ Asthma ¶ Drug reactions ¶ Other _____

Please list any additional information you are concerned about and would like to discuss in your appointment today:

_____

_____

_____

_____

_____