ANDERSON SPECIFIC CHIROPRACTIC

1099 Merchants Dr. Suite B ~ Dallas, GA. 30132
Phone: (770) 443-4225 ~ Fax: (770) 443-3890 ~ Email: info@andersonspecific.com

Pediatric Initial Information

CONTACT INFORMATION:

Child's Name: ____ Child's Social Security: _____-_______-______
Last **First** **Middle**

Mother's Name: __________________________________ Father's Name ______________________________
Address: ____ City: _____________________ State: ______ Zip:__________
Home Phone:_______________ Mother's Wk/Cell :________________ Father's Wk/Cell _____________________
Fathers Email: ___________________________________ Mothers Email: _______________________________________
Obstetrician/Midwife:
____
Name Location Phone #
Pediatrician/Family MD:
____
Name Location Phone # Date of Last Visit
____

PEDIATRIC PATIENT CASE HISTORY

Patient's Name: ____ Date of Birth: ______/______/______ Gender: M F
Reason for this visit:
____
Age:______ Birth Weight: _____ Current Weight:______ Birth Length:______ Current Length: ______ # of Siblings:______
Childs Congenital Anomalies/Defects:
____
Family History of Congenital Anomalies/Defects:
____
Type of Birth (circle all that apply): Normal Vaginal Forceps Suction Breech Cesarean Cord around neck
Birthing Location: Home Birth Birthing Center:___________________________Hospital:___________________________
Pregnancy History / Problems during Pregnancy:
____
____
Delivery & Birth History / Problems during Labor & Delivery:
____
____
APGAR Scores: ____ ____ Was there presence at birth of: ____ Jaundice (yellow) ____ Cyanosis (blue)
Infant Feeding: Breast: ____ # of Months: _______ Bottle: ____ # of Months: _______
Formula: _____ # of Months: _______ Brand(s): ___________________________________
Number of Hours of Sleep Per Night: ________ Quality of Sleep (circle): Good Fair Poor

Immunization History:
____
____
Developmental History - At what age did the child:

1099 Merchants Dr. Suite B ~ Dallas, GA. 30132

Phone: (770) 443-4225 ~ Fax: (770) 443-3890 ~ Email: info@andersonspecific.com

_____ Respond to sound _____ Sit unaided _____ Follow an object with his/her eyes _____ Hold head up _____ Walk unaided _____ Crawl ________ Stand unaided ___

Childhood Diseases:

Chicken Pox ___ Mumps ___ Measles ___ Rubella ____ Rubella ___ Whooping Cough

Other:____

Has this child ever suffered from: (check all that apply)

__ Dizziness __ Bed wetting __ Tuberculosis __Blood Disorders __ Chronic earaches

__ Diabetes __ Digestive Disorders __ Headaches __ Heart trouble __ "Growing pains"

__Arthritis __ Fainting __ Hyperactivity __ Hypertension __ Allergies

Continue:

__ Neuritis __ Neck problems __ Convulsions __ Asthma __ Constipation

__ Anemia __ Joint problems __ Rheumatic Fever __ Sinus trouble __ Diarrhea

__ Poor appetite __ Backaches __ Arm problems __ Walking problems __ Behavioral problems

__ Paralysis __ Broken bones __Leg problems __ Muscle jerking__ Colds/Flu ___Stomach Aches ___Ruptures/Hernias

Other:____

Present History & Allergies:

____

____

____

Surgeries:

____

Accidents, Falls or Traumas:

____

____

Medications:____

Family History:

____

____

INSURANCE INFORMATION:

Primary Secondary (if applicable)

Who is responsible for this account? ____

Relationship to Patient: ____

Insurance Co: ____

ID Number: ____

Group #: ____

ASSIGNMENT & RELEASE – PLEASE NOTE: YOU MUST SIGN BELOW EVEN IF YOU DO NOT HAVE INSURANCE

I, the undersigned certify that my dependant has insurance coverage with ______________________________ and assign directly to Dr. Anderson 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 for by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions..

____/________________________/_____/____/____

Responsible Party Signature Relationship to Patient Date

Anderson Specific Chiropractic

1099 Merchants Dr. Suite B ~ Dallas, GA. 30132

Phone: (770) 443-4225 ~ Fax: (770) 443-3890 ~ Email: info@andersonspecific.com

AUTHORIZATION FOR CARE OF A MINOR

Chiropractic examination and Chiropractic care including but not limited to spinal adjustments. Any procedure intended to help may have complications. While the chances of experiencing complications are small it is the practice of this clinic to inform our patients about them. These complications include, but are not limited to, soreness, inflammation, soft tissue injury, dizziness, burns, and temporary worsening of symptoms. More serious complications are extremely rare. Additional information on side-effects and complications is available upon request.

I have read and understand the above statements regarding treatment side effects. I also understand that there is no guarantee or warranty for a specific cure or result.
I HEREBY AUTHORIZE Anderson Specific Chiropractic INC. AND ITS DOCTOR(S) TO ADMINISTER CARE AS THEY DEEM NECESSARY FOR MY CHILD/WARD.

____/_____________________. ______/____/_________

PARENT / GUARDIAN SIGNATURE **RELATIONSHIP TO PATIENT** **DATE**