**_RAINIER VALLEY CHIROPRACTIC P.S._**
*David A. Butters D.C. — Natasha Butters D.C.*
4236 36th Avenue S. Seattle, WA 98118
Phone 206-723-2820 Fax 206-722-3664

# PEDIATRIC HISTORY FORM

Date:_____

Child's Name: _____ Phone: _____
(First Name) (Middle) (Last Name)
Street Adress:_____ City: _____ State: _____ Zip Code: _____

❑ Male ❑ Female Date of Birth ____/____/_____ Age _____ Social Security Number ____/____/_____

Who Referred You to Our Office? _____ Are you insured? ❑ No ❑ Yes

Was your child injured in an automobile accident? ❑ No ❑ Yes, Date: ____/____/_____

If yes, Was your child riding in a safety seat? ❑ No ❑ Yes

Where was the seat in the car? ❑ Front seat ❑ Back seat ❑ Facing forward ❑ Facing backward

Where was the impact on your car?
Front of car: ❑Front end ❑Driver's side ❑Passenger's side
Rear end of car: ❑Rear end ❑Driver's side ❑Passenger's side
Side of car: ❑Broadside/Side-swipe ❑Front half of car ❑Back half of car

List any bumps, bruises, scrapes, cuts, etc. on your child that were caused by this accident:
_____
_____
_____

| | |
|---|---|
| Has there been a change in your child's eating habits? | ❑ No ❑ Yes |
| Has there been a change in your child's sleeping habits? | ❑ No ❑ Yes |
| Has there been a change in your child's disposition? | ❑ No ❑ Yes |
| Does your child have a fever of unknown origin? | ❑ No ❑ Yes |
| Does your child have a recent change in "Bathroom" habits? | ❑ No ❑ Yes |
| Has your child become restless or irritable? | ❑ No ❑ Yes |

**BIRTH HISTORY**:

Delivery was: ❑ Vaginal ❑ Cesarean

Were any extraction aids used in the birth process? ❑ No ❑ Yes, explain:
_____
_____

Was labor prolonged? ❑ No ❑ Yes

Was this a multiple birth? ❑ No ❑ Yes, how many? _____

Was the birth premature? ❑ No ❑ Yes, how early? _____

List any significant illnesses, hospitalizations, etc.: _____
_____
_____

**(Parent/Guardian Signature)** **(Printed Parent/Guardian Name)** **(Date)**

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Name_____ Date: _____/_____/_____

## HEALTH INSURANCE INFORMATION

***Patient's Name***_____ ***DOB***_____
***Insured's Name***_____ ***Insured's DOB***_____
***Insured's Address if different than yours***_____
_____
**ID#**_____ **Group#**_____
**Insurance Company**_____

**Please present insurance card to front desk so we can make a copy for your file.**

***If not insured, list the Name & Address of person RESPONSIBLE FOR PAYMENT.**

_____
_____
_____
_____

## ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize payment directly to Rainier Valley Chiropractic, P.S. for the chiropractic services that I am provided. I understand that it is my responsibility to check my health plan for any special requirements (i.e. prior authorization, referral from PCP, etc.) prior to receiving care. I also understand that I am financially responsible to the doctor for charges not covered by my insurance.

Signature: _____ Date:_____
(*Policy Holder/Child's Guardian)*