32 E. Main St. Waconia, MN 55387
952-442-9727

Pediatric History & Adolescent Form (birth to 16 years)

Patient Name: _____ Middle Initial: _____Nick-Name: _____ Date: _____

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

Birth Date: ____/____/____ Sex: _____ Weight: _____ Height: _____

Whom may we thank for referring you to our office? _____

Father's Name: _____ Mother's Name: _____

Father's Cell: _____ Mother's Cell: _____

Home Phone: _____ Email: _____

Name of Insurance Company: _____ Primary Cardholder: _____

Birth Date of primary cardholder: _____

Parent's marital status (please circle): Single Married Divorced Widowed

In the event we need to contact you, what is the best method of communication for your family? (Circle one)

Phone Email Text

At our office we are interested in your entire family's health and well-being. Please mention below any health conditions or concerns you may have about yourself or other members of your family:

Yourself/Spouse: _____ Other Children: _____

Others: _____

Purpose for Contacting Us (please circle any of the following): Spinal Check-Up Wellness Other

Please Explain: _____

If Applicable: Other Doctors Seen for This Condition: _____NO _____YES

Doctors Name, Clinic Location and Prior Treatments:

_____

Previous Chiropractor: _____

Date of Last Visit: _____ Reason: _____

Are we coordinating care with your physician? _____No _____Yes

Name of Pediatrician: _____ Date of Last Visit_____

Reason: _____

Please mark a "P" if it is a *Past Condition* or an "N" if it is a *Present Condition*

____Ear Infections	____Scoliosis	____Seizures	____Chronic Colds
____ Headaches	____Asthma	____Allergies	____ Digestive Problems
____ ADHD	____Recurrent Fevers	____Growing Pains	____Colic
____ Bedwetting	____ Anemia	____ Reflux	____Behavioral
____Leg Problems	____Poor Posture	____Broken Bones	____Heart Trouble
____Stomach Aches	____Muscle Pain	____ Orthopedic Problems	____ Neck Problems
____Joint Problems	____Constipation/Diarrhea	____ Poor Appetite	____ Arm Problems
____Back Problems	____Walking Trouble	____Sinus Trouble	____Diabetes

Other: _____

Number of doses of Antibiotics your child has taken:

_____

Please list any drugs or medications (prescription or over the counter) your child is taking: _____

Please list any vitamins/supplements/herbs/homeopathic/other your child is taking:

_____

Prenatal History

Name of Obstetrician/Midwife: _____

Complications during Pregnancy: ___No ___Yes List: _____

Medications during Pregnancy/Delivery: ___No ___Yes List: _____

Cigarette/Alcohol use during Pregnancy ___No ___Yes List: _____

Location of Birth: ___ Hospital ___ Birthing Center ___ Home

Birth Intervention: ___Forceps ___ Vacuum Extraction ___C-Section (emergency or planned?)

Complications with Delivery: ___No ___Yes List:

_____

Genetic Disorder or Disabilities: __No ___Yes List: _____

Birth Weight: _____ Birth Length: _____ APGAR Scores: _____

Feeding History: (Infants and Toddlers Only)

Breastfed: ___No ___Yes How Long? _____ Formula Fed: ___ No ___ Yes How Long? _____

Does the baby prefer feeding on one side over the other? ____Yes ____No Introduced to solids at: _____ Months

Cow's Milk at _____Months

Food/Juice Allergies, Sensitivities or Intolerance: ___Yes ___No, List:

_____

Developmental History

During the following times your child's spine is most vulnerable to stress and should be routinely checked by a doctor of chiropractic for prevention and early detection of a ***vertebral subluxation*** (spinal nerve interference). At what age was your child able to:

_____Respond to Sounds _____Cross Crawl _____Hold Head Up

_____ Sit up _____Stand Alone _____Walk Alone

Research is showing that many health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please (X) the appropriate answer to the following questions to the best of your ability.

Did your child have a traumatic birth? _____Yes _____No _____Unsure

Has your child had any serious falls? _____ Yes _____No _____Unsure

Did/Does your child play sports? ____Yes ____No _____Unsure

Has your child been involved in a car accident? _____Yes _____No _____Unsure

Has your child been under chiropractic care? _____Yes _____No _____ Unsure

On average how many hours of sleep does your child get per night? _____

We are honored that you have chosen us to assist you and your family's health and wellness needs. Please let us know if there is any way we can make you and your family more comfortable. We look forward to working with you to build better health for your family.

Soltis Family CHIROPRACTIC
32 E. Main St. Waconia, MN 55387
952-442-9727

Acknowledgment of Receipt of Notice

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. These rights are more fully described in **Soltis Family Chiropractic's** Notice of Privacy Practices. **Soltis Family Chiropractic** is permitted to revise its Notice of Privacy Practices at any time. We will provide you with a copy of the revised Notice of Privacy Practices upon your request.

Those individuals or parties that could have access to Patient Health Information at **Soltis Family Chiropractic** include but may not be limited to:

The Staff of **Soltis Family Chiropractic** this includes:

Dr. Jeff Soltis, Dr. Leah Soltis, Dr. Matt Feriancek,Kellie Schultz CA, and Kristie Dustin CA, Megan Goldman CA, and Lindsay Beletti PR.

By signing below, you are acknowledging that you have reviewed a copy of Soltis Family Chiropractic's Notice of Privacy Practices.

Patient Name: _____

Patient Date of Birth: _____ Patient Social Security Number: _____

Patient Representative: _____

If signed by Patient Representative, state authority to act on behalf of patient: _____

_____

Signature: _____ Date: _____

SOLTIS FAMILY CHIROPRACTIC USE ONLY

I, _____, attempted to obtain the patient's acknowledgement of receipt of the Notice of Privacy Practices, but was unable to do so.

Reason acknowledgment not obtained: _____

_____

Signature: _____ Date: _____

OFFICE FINANCIAL POLICY

CASH

1. All patients are on a cash basis until their respective insurance coverage and deductible, can be verified by our staff.

2. This office may make payment plan arrangements on an individual basis. Any such plan of arrangement will be discussed during your report of findings.

INSURANCE

1. If you have insurance we will gladly process any paperwork and insurance information needed for insurance reimbursement. Provided we have prior certification from your insurance company.

2. We provide the information for insurance reimbursement as a courtesy to you. You are responsible for the bill or services rendered whether or not insurance covers the care. We are not a mediator between you and your insurance company and will not enter into any dispute, as your contract is between you and your insurance company.

3. All services are to be paid for at the time of service or through the contract agreed upon by both parties involved.

Thank you,

I have read and understand the Financial Office Policy and agree to abide by these terms.

Patient's Signature Date

NAME OF PATIENT:_____

DATE _____

CONSENT TO TREATMENT OF MINOR CHILD

CONSENT TO TREATMENT OF ADULT WITH MEDICAL POWER OF ATTORNEY

I hereby authorize Dr. _____ and whomever he/she may designate as his/her assistants to administer treatment as he/she so deems necessary to _____ (Name of Patient).

Dated at _____ this

_____ day of _____, 20_____.

PRINTED NAME OF PERSON AUTHORIZING TREATMENT:

_____

Signature_____

RELATIONSHIP TO PATIENT: _____