Rhino Chiropractic Center

Pediatric Application & History

Dear Parents & New Patient,
It is a pleasure to welcome you to our happy and healthy Rhino family! Please let us know if there is any way we can make you and your family feel more comfortable. To help us serve you better, please complete the following information. We look forward to working with you to build better health for your family!

Patient Name: ________________________________ **Date of Birth:** _______________

Street Address: _______________________________ **Home Phone:** _____-_____-_____

City: __________________________ **State:** ________ **Zip Code:** ______________

Mother: ________________________ **Father:** ___________________________
Work Phone: _____________________ **Work Phone:** ______________________
Cell Phone: ______________________ **Cell Phone:** ________________________

Parent's Marital Status: ______________ **Predominant Language at Home:** _________________________
Siblings? Please list their ages: ____

Purpose for contacting us?: ____

Other doctors seen for this condition? Please list their names and prior treatment:
____
____

Any other Health Concerns: ____

Name of Pediatrician: _________________ **Last visit:** ___________ **Reason:** ________________________
Are you satisfied with the care you receive there? Y / N

Previous Chiropractor: ________________ **Last visit:** ___________ **Reason:** ________________________

Check any of the following conditions your child has experienced in the past six months:

__ Ear Infections	__ Scoliosis	__ Chronic Colds	__ Seizures	__ Growing/Back Pains
__ Headaches	__ Asthma/Allergies	__ Temper Tantrums	__ Colic	__ Car Accident
__ Fevers	__ ADHD	__ Digestive Problems	__ Constipation	__ Bed Wetting

Family History of Illness/Disease: ____
____
____

I. Prenatal History

Name of Obstetrician/Midwife: _________________________ **Location of birth: Birthing Center / Hospital / Home**
Complications during pregnancy: ____
Number of ultrasounds during pregnancy: ______ **Cigarette/Alcohol use during pregnancy:** ___________________
Medications used during pregnancy: ____
Intervention during birth: Forceps / Vacuum Extraction / Ceasarean –Planned/Emergency
Complications during delivery: ____
Genetic Disorders/Disabilities: ____
Birth Weight: __________ **Birth Length:** _________ **APGAR Scores:** __________

II. Newborn History (Birth to 2 months)

(if your child is older than 2 months, please skip to section III. Infant History)

Hours your baby sleeps between feeding? Daytime: _______________ Night: __________________
Does your baby go to sleep easily? ____
Any preferred sleeping position? ____
Does your baby cry if you change this position? ____
Is your baby being breast-fed or formula fed? ____
Does your baby have a one-sided breast-feeding preference? ____
Does your baby have any feeding difficulties? ____
Does your baby frequently spit-up after feeding? ____
Does your baby cry a lot? How many hours per day? ____
Does your baby pass a lot of intestinal gas? ____
Does your baby have a preferred head position? ____
Does your baby frequently arch her head/neck backwards? ____
Has your baby ever had a fever? ____
Has your baby ever had any falls? ____
Do you have any other concerns? ____

Please skip to section V. Developmental History

III. Infant/Toddler History (2 months to 2 years)

(if your child is older than 2 years, please skip to section IV. Child History)

Is your child still being breast-fed? How long was he/she breast-fed? ____
Is your child formula-fed? ____
Is your child eating solid foods? What foods does his/her diet contain? What is your child's favorite food? ________________
____
Does your child have any feeding difficulties? ____
Is your child a picky eater? ____
Does your child have any digestive disturbances? ____
Does your child have any food allergies/intolerances? ____
Does your child have persistent skin rashes? ____
Is your child receiving any vitamin supplements? ____
Has your child had any ear infections? ____

Please skip to section V. Developmental History

IV. Child History (2 years and beyond)

Does your child complain of discomfort or pain, constant or intermittent? ____
Has your child ever had this problem before? ____
Does your child ever complain of back or neck pain? ____
Does your child ever complain of pains in arms/legs? ____
Does your child ever complain of headaches? ____
Has your child had asthma? ____
Is your child allergic to anything? _______________________ Are there smokers in the child's home? ________
Has your child had any earaches or ear infections? __________________ At what age was their first earache? ___________
How frequently does your child have earaches? ____
In which ear does your child's earaches occur? ____
Is your child presently taking any prescribed medication? ____
Do you have any other health concerns? ____
For how many months was your child breast-fed? ____
What does your child eat for breakfast? ____
What does your child eat for lunch? ____
What does your child eat for dinner? ____
What are your child's snacks? ____
How much cow's milk does your child drink each day? _____________ Does your child eat fast foods? _________________
What is your child's favorite food? ____

Has your child ever fallen from a bicycle/skateboard/etc? ____
Does your child play any high-contact sports? ____

V. Developmental History

Number of doses of Antibiotics taken:

During the past six months: ____________________
During his/her lifetime: ________________________

Number of other prescribed medication taken:

During the past six months: ____________________
During his/her lifetime: ________________________

Vaccinations: ___ **I am following my pediatrician's recommended schedule of vaccines**
___ **I am following an alternative vaccination schedule**
___ **I have not vaccinated my child**

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

_____ Respond to Sound _____ Hold Head Up _____ Sit Up _____ Respond to Visual Stimuli
_____ Stand Alone _____ Walk Alone _____ Cross Crawl

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e. bed/changing table/stairs). **Did your child have a fall during their first year of life?:** _________________________

Does your child ever bang their head repeatedly? ____
Has your child ever fallen down stairs or from a significant height? ____
Has your child ever had a bone fracture or joint dislocation? ____
Has your child ever been in a car accident? ____
Please describe any other traumas: ____
Please describe any surgeries your child has had: ____

Office Fee Schedule, Financial Policy & Consent to Treat

Health Insurance

If you expect your health insurance to contribute to the cost of your child's care, please allow us to copy your insurance card. We will verify your policy's chiropractic coverage, and provide you with an explanation of your insurance coverage at your report of findings.

Subscriber Name: _________________________ **Insurance:** __________________________________
Group #: __________________________________ **Policy #:** __________________________________

I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize Dr. Ciasullo to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to Dr. Ciasullo any and all plan documents, insurance policy and/or settlement information upon written request from the doctor in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with Dr. Ciasullo against such insurers and/or employee health care plan in my name but at the doctor's expense.

Signature: ____ **Date:** _______________________

Consent to Treat

Being the parent or legal guardian of this child, I hereby authorize this office and its doctors to examine and administer care to my son/daughter (patient named above) as the examining treating doctor deems necessary. I understand and agree that I am personally responsible for payment of all fees charged by this office for such care.

Parent's Name: ____________________________ **Signature:** ______________________________ **Date:** ________________