Hoglen Chiropractic & Laser

PEDIATRIC PATIENT HEALTH HISTORY FORM

PATIENT INFORMATION

Legal Name: _____ **Called Name:** _____
LAST FIRST MIDDLE (If different than legal name)

Date of Birth: _____ **Sex (legal):** ❑ Male ❑ Female **Pronouns:** ❑ He/Him ❑She/Her ❑ They/Them

Address: _____
STREET CITY STATE ZIP

Parent/Guardian Name(s): _____

Primary Phone: _____ ❑ Cell ❑ Home **Who does this # belong to?** _____

Secondary Phone: _____ ❑ Cell ❑ Home **Who does this # belong to?** _____

Email Address: _____

Emergency Contact: _____ **Relationship:** _____ **Phone:** _____

Health Insurance Provider: ❑ Blue Cross Blue Shield ❑ Medicare ❑ Other: _____

Do you have a secondary Insurance? ❑ Yes ❑ No **If yes, who is your provider?** _____

How did you find out about our office? ❑ BCBS ❑ Google ❑ Facebook ❑ Referred by _____

CURRENT CONDITION

What is the primary reason for your visit today? ❑ Wellness Check ❑ Scoliosis Evaluation ❑ Other (describe below)

Primary Complaint: _____ **When did this condition Begin?** _____

Rate the Pain from 1 (least pain) to 10 (severe pain): _____ **Does this occur:** ❑ Daily ❑ Weekly ❑ Monthly

Is the persistence of this pain: ❑ Intermittent (0-25%of the time) ❑ Occasional (25-50% of the time) ❑ Frequent (51-75% of the time) ❑ Constant (76-100% of the time)

Has this condition occurred before? ❑ Yes ❑ No **Please Describe:** _____

List other doctors who have seen you for this condition: _____

Please describe treatments: _____

Has your child's daily behavior/activity been affected by this? ❑ Not at all ❑ Somewhat ❑ Significantly

GENERAL HEALTH

Is your child vaccinated? ❑ Yes ❑ No ❑ Other Schedule: _____

Was/Is your child fed: ❑ Breastmilk ❑ Formula **If breastfed, did/does your child prefer one side?** ❑ R ❑ L

Please list all current Medications: _____

Please list all current Supplements: _____

Please list all current Health Conditions: _____

Current Height: _____ **Weight**: _____ **Is your child Right or Left Handed?** ❑ R ❑ L ❑ Unknown

Does your child:

Drink Soda/Pop	❑ Never	❑ Rarely	❑ Occasionally	❑ Frequently
Sleep All Night	❑ Never	❑ Rarely	❑ Occasionally	❑ Frequently
Play Sports	❑ Never	❑ Rarely	❑ Occasionally	❑ Frequently
Use a phone/tablet	❑ Never	❑ Rarely	❑ Occasionally	❑ Frequently

Please List any known allergies (including food sensitivities) your child has currently or has had in the past:

_____

PAST HEALTH STATUS

Previous Chiropractic Care? ❑ Yes ❑ No **If Yes, Previous doctor:** _____ **Last Visit Date:** _____

List any Surgeries/Operations: _____

List any Accidents or Major Falls: _____

List any additional hospitalizations: _____

Did your child have any prenatal conditions (if so, please describe)? ❑ Yes ❑ No _____

Had your child ever taken antibiotics? ❑ Yes ❑ No **If yes, for how long?** _____

Please check any of the following conditions your child has had EVER IN THE PAST:

	Pneumonia		Anemia		Covid-19		Influenza		Eczema
	Rheumatic Fever		Measles		Diabetes		Pleurisy		HIV
	Polio		Mumps		Cancer		Arthritis		Epilepsy
	Tuberculosis		Chicken Pox		Heart Disease		Rheumatoid Arthritis		
	Whooping Cough		Small Pox		Thyroid Disease		Psoriatic Arthritis		

Please check any of the following conditions your child has had IN THE LAST 6 MONTHS:

MUSCULOSKELETAL		**GASTROINTESTINAL**		**CARDIOVASCULAR/RESP**		**EENT**		**NERVOUS SYSTEM**	
	Low Back Pain		Poor Appetite		Chest Pain		Sore Throat		Dizziness
	Upper Back Pain		Excessive Appetite		Shortness of Breath		Ear Aches		Numbness
	Neck Pain		Excessive Thirst		Heart Abnormality		Hearing Difficulty		Palsy / Paralysis
	Arm/Shoulder Pain		Nausea		Ankle Swelling		Stuffy/Runny Nose		Convulsions/Tremor
	Hip/Leg Pain		Vomiting		Irregular Heartbeat		Sinus Pressure		Fainting
	Joint Stiffness		Diarrhea		Heart Disease		Tonsillar Swelling		Seizures
	Difficulty Walking		Constipation		Lung Problems		Eye Pain	**MENTAL HEALTH**	
	Difficulty Chewing		Hemorrhoids		Chest Congestion		Itching Eyes		Forgetfulness
	Clicking Jaw		Abdominal Cramps	**MALE/FEMALE**			Vision Problems		Cold/Tingling Extremities
GENERAL			Liver Problems		Chest/Breast Lumps		Dental Pain/Problems		Stress / Anxiety
	Fatigue		Gall Bladder Problems		Genital Pain/Infection	**GENITO-URINARY**			Depression
	Allergies		Bloating After Meals		Menstrual Pain		Bladder Trouble		Nervousness
	Loss of Sleep		Heartburn				Painful Urination		Confusion
	Fever		Black/Bloody Stool				Excessive Urination		
	Headaches		Colitis				Discolored Urine		

Have any immediate family members been diagnosed with: ❑ Heart Disease ❑ Diabetes ❑ Cancer ❑ Stroke

Is your child adopted? ❑ Yes ❑ No **If Yes, do they know they are adopted?** ❑ Yes ❑ No

AUTHORIZATION OF CARE

I authorize payment of insurance benefits directly to Dr. Andrea Hoglen and her office, Hoglen Chiropractic and Laser, PLLC. I authorize this office to release all information necessary to communicate with my health insurance providers, their representatives, and payors in order to secure the payment of my health insurance benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

Patient Name (Print): _____ **Parent/Guardian Name (print):** _____

Parent/Guardian Signature: _____ **Date:** _____