Upper Cervical Health Centers®

Pediatric Health History Form

Date: ________________________

Name: ____

Address: ___________________________________**City**______________________**State**_______**Zip**_________

Phone :(H) ___________________ **Date of Birth:** ____________________**Age**:________

Parent/Guardian Name(s) ____

Circle all that Apply

1. Was child's birth traumatic?

Long Delivery? Y N ____
Difficult Delivery? Y N ____
Forceps? Y N ____
Caesarean? Y N ____
Breach/cephalic Y N ____
Home birth? Y N ____
Mother given drugs during delivery? Y N ____

2. Growth and Development

Did child ever once....
Fall out of bed? Y N ____
Bang their head? Y N ____
Breastfeed? Y N ____
Have childhood sickness? Y N ____
Have any accidents? Y N ____
Have surgery? Y N ____
Take drugs? Y N ____
Fall while learning how to walk? Y N ____
Bullied by siblings? Y N ____
Chair pulled our when sitting? Y N ____
Fall down the stairs? Y N ____
Pulled by their arm? Y N ____
Experience other traumas? Y N ____

3. Current Health Habits

Does child
Smoke? Y N ____
Drink alcohol? Y N ____
Consume healthy foods? Y N ____
Take any drugs? (Prescriptive Y N ____
Or non-prescriptive)? Y N ____
Have teeth problems? Y N ____
Have hearing problems? Y N ____
Exercise regularity? Y N ____
Have sleeping problems? (nightmares)? Y N ____
Have physical stress? Y N ____
Have mental stress? Y N ____
Have hobbies/sports injuries? Y N ____

Childs normal sleeping posture (CIRCLE) on side on stomach on back

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Current Health Condition

Major complaint/reason for visit today____

____

Pain or problem started on____

Pains are:(Circle one) Sharp Dull Constant Intermittent

What activities aggravate your condition/pain? ____________________________________
What activities lessen your condition/pain? _______________________________________
Is condition worse during certain times of the day? _________________________________
Is this condition interfering with sleep? _________ Daily activities? _________School?_________
Is this condition getting progressively worse? _____________________________________
Other Doctors seen for this condition____

Other symptoms:

☐ Headaches	☐ Face flushed	☐ Light sensitive eyes	☐ Feet cold
☐ Neck pain	☐ Neck stiff	☐ Loss of memory	☐ Hands cold
☐ Sleeping problems	☐ Pins & needles in legs	☐ Ears ring	☐ Stomach upset
☐ Back pain	☐ Pins & needles in arms	☐ Fever	☐ Constipation
☐ Nervousness	☐ Numbness in fingers	☐ Fainting	☐ Loss of balance
☐ Tension	☐ Numbness in toes	☐ Cold sweats	☐ Buzzing in ear
☐ Irritability	☐ Shortness of breath	☐ Loss of taste	☐ Diarrhea
☐ Chest pains	☐ Fatigue	☐ Dizziness	☐ Depression

What medications are currently being taken? (Include vitamins, supplements and over the counter drugs)
____

____

Has the child had surgery or any medical procedure? If "yes" describe procedure(s) ________________________

____

What side effects, if any, has the child experienced from medications or surgery? ____________________

____

Is there a family history of: (check all that apply)

	Heart Disease	Arthritis	Cancer	Diabetes	Other_________
Father's side	☐	☐	☐	☐	☐
Mother's side	☐	☐	☐	☐	☐

____ ____________________
Parent/Guardian Signature Date

Disclosure of Fee's/Payment Policy

As May 1, 2014

99201 Focused Initial History and Exam	$70.00
99202 Limited Initial History and Exam	$95.00
99203 Intermediate Initial History and Exam	$135.00
99204 Comprehensive History and Exam	$185.00
99211 Brief Exam	$42.00
99212 Focused Exam	$52.00
99213 Expanded Exam	$85.00
99214 Detailed Exam	$135.00
98940 chiropractic Manipulative Treatment: Spine, one or two regions	$52.00
98941 Chiropractic Manipulative Treatments: Spine, three or four regions	$71.00
98942 Chiropractic Manipulative Treatments: Spine, five or six regions	$92.00
98943 Extra spinal, one or more regions	$45.00
97710 Therapeutic exercises 15 minutes of less	$45.00
97140 Manual Therapy techniques 15 minutes or less (1 unit)	$42.00
97112 Neuromuscular re-education (1 unit)	$42.00
72020 Cervical 1 view	$42.00
72040 Cervical 2 views	$100.00
72050 Cervical 4 views	$200.00
72052 X-Ray Davis Series	$250.00
72052-52 X-Ray Davis Series	$225.00

I have read the above codes and fees and I understand the cost of my care with my treating doctor. I understand that I am responsible for payment of all services. If my balance is not paid in a timely and monthly fashion, I promise to pay any and all collection, court and attorney's fees in the collection of my account. I understand that if a check or debit is returned for insufficient funds, I will be charged $35.00 service charge.

Authorization To Pay Doctor/Clinic

I hereby authorize and direct payment of any medical expense benefits allowable to the doctor/clinic named below as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to the doctor/clinic. I agree that a photo static copy of this agreement shall serve as the original.

________________________ ________________________

Signature Date

Authorization to Pay/Release Is Granted to: Upper Cervical Health Centers

Consent For Treatment Of Minors

I (We) being parent, guardian or custodian of ____, a minor the age of ____________, do hereby authorize, request and direct Dr. ___________________________________ to perform any exam, x-ray and Upper Cervical chiropractic treatment for their condition as he deems necessary.

____ ______________________________________

Parent, Guardian or Custodian *Date*