Yaeger Chiropractic & Nutrition
1875 Olympic Blvd Ste. 150
Walnut Creek, CA 94596
925-947-0188

Pediatric/Adolescent Health History Intake Form

Last Name:_____ First Name:_____ Date of Birth:_____ Age:_____ Sex: _____

Guardian's Name:_____ Email:_____ Contact #: _____

Address: _____ City: _____ St: _____ Zip: _____

PRENATAL HISTORY

A. Mother's Pregnancy: □Normal □Complications: _____
B. Gestation:_____weeks
C. Birth Location: □ Hospital □ Birthing Center □ Home □ Other _____
D. Delivery: □ Vaginal □ C-Section □ Induced - Complications: □ No □ Yes _____
E. Birth Weight:_____lbs_____oz_____Length:_____inches

PRESENT HEALTH CONCERNS Please list most important health concerns in their order of significance

1. _____
2. _____
3. _____
4. _____

CURRENT MEDICAL HISTORY

MEDICATIONS: Please list all medication + over the counter medications that your child is taking with dosages.

1._____ 4. _____
2._____ 5._____
3._____ 6._____

SUPPLEMENTS: Please list vitamins, minerals, herbs, homeopathic remedies that you are currently taking, with dosages

1._____ 4. _____
2._____ 5._____
3._____ 6._____

ALLERGIES: Please include mild to severe or life-threatening allergies and reaction (symptoms)

1. Medications:_____
2. Environment: _____
3. Food: _____

IMMUNIZATIONS

Please place an **X** next to each vaccination that your child has received.

	Hepatitis A		Measles
	Hepatitis B		Mumps
	Diphtheria		Rubella
	Pertussis		Varicella (Chicken Pox)
	Tetanus		Influenza
	Hemophilus Influenza Type B		Rotavirus
	Polio		Human Papilloma Virus (HPV)
	Pneumococcal		

Has your child ever had a reaction to an immunization? Yes No

If so, which vaccine and what was the reaction:_____

PAST MEDICAL HISTORY

CHILDHOOD ILLNESSES: (Circle and indicate age of illness, If current, write in a C for age)

Acne:	Yes/Age:	Ear Infections:	Yes/Age:
ADD:	Yes/Age:	Eating Disorders:	Yes/Age:
ADHD:	Yes/Age:	Eczema:	Yes/Age:
Alcohol use:	Yes/Age:	Headaches:	Yes/Age:
Allergies:	Yes/Age:	Head lice:	Yes/Age:
Asthma:	Yes/Age:	Mononucleosis:	Yes/Age:
Bedwetting:	Yes/Age:	Obesity/Overweight:	Yes/Age:
Behavior problems:	Yes/Age:	Pink eye:	Yes/Age:
Bronchitis	Yes/Age:	Pneumonia:	Yes/Age:
Colic:	Yes/Age:	Colds:	Yes/Age:
Constipation:	Yes/Age:	Sinus Infection:	Yes/Age:
Cough:	Yes/Age:	Thrush:	Yes/Age:
Croup:	Yes/Age:	Vomiting:	Yes/Age:
Depression/ Anxiety	Yes/Age:	Whooping cough:	Yes/Age:
Diaper Rash:	Yes/Age:	Other Illness:	Yes/Age:
Diarrhea	Yes/Age:		
Drug Abuse	Yes/Age:		

Please comment on any illnesses indicated above: _____

_____

_____

_____

SOCIAL HISTORY

NUTRITIONAL HISTORY:

Infant/Toddlers:

Type: □Nursing □Formula/Specify_____ □Both

Duration: □<15 min □15-30 min □30-45 min □45-60 min

Frequency: □Every hour □Every other hour □Every 3 hours □Every 4 hours □Every 5 hours

Amount of formula per feeding: □<1oz □1-2oz □2-3oz □3-4oz □>4oz

Has child started solids yet? If so what type_____

How much juice does your infant/toddler drink in a day_____ water_____

What type of milk does your child drink_____ How much per day_

School Agers/Adolescents:

What is a typical breakfast_____

What is a typical lunch _____

What is a typical dinner _____

What are typical snacks _____

How many glasses of water does child drink each day_____

Does child have any special dietary restrictions? _____

EXERCISE:

Do your child exercise regularly? □ Yes □ No

What type/activity_____ How long_____

How often_____

SLEEP:

How many hours of sleep does your child get at night on average _____

Does your child have trouble falling asleep? □ No □ Yes/ Why_____

How often does your child wake up in the middle of the night and for what reasons _____

_____

Does your child have trouble waking up? □ No □ Yes/Why _____

Does your child feel rested when they wake up? □ Yes □ No/Why_____

ENERGY AND STRESS:

Adolescents:

How would you rate child's energy on a scale of 1 – 10 with 10 being the most energy?

How would you rate child's stress on a scale of 1 – 10 with 10 being the most stress?

How does child cope with stress?

TRAVEL HISTORY:

Identify any foreign travel and indicate year of travel:

Place: _____Year_____Place:_____Year:_____

SOCIAL HISTORY – Teenagers/Adolescents Only

SUBSTANCE USE:
Identify any substances you have used and circle whether in the past (P) or are currently using (C)

Nicotine:	P	C	Freq: _____	Tobacco:	P	C	Type/Freq_____
Coffee:	P	C	Freq: _____	Recreational Drugs:	P	C	Type/Freq_____
Alcohol:	P	C	Freq: _____	Other:	P	C	Type/Freq _____

BIRTH CONTROL:
Are you sexually active with Men Women Both?
What form of contraception/birth control are you using (Check all that apply)
□ Withdrawal □ Condom □ The Pill □ The Shot (Depo-Provera) □ The Ring □ Implants □ The Patch
□ Fertility Awareness Method □ The Sponge □ Spermicide □ Diaphragm □ Cervical Cap
□ None

FAMILY HISTORY

Please place a "C" for current or "P" for past in the box next to each condition as it applies to your family members.

	Mother	Father	Sibling	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Alcoholism							
Allergies							
Anemia							
Arthritis							
Asthma							
Cancer							
Depression							
Diabetes							
Drug Addiction							
Eczema / Psoriasis							
Epilepsy							
Headaches							
Heart Disease							
Hepatitis							
High Blood Pressure							
Kidney Disease							
Stroke							
Tuberculosis							

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P: 925-947-0188 F: 925-264-5734

Consent to Treatment of Minor

I (we) being the parent or legal guardian of_____, a minor the age of_____do hereby consent, authorize and request Dr. Yaeger to administer such treatment deemed advisable necessary or requested on above minor.

Parent/Guardian Signature:_____

Date:_____

Witness:_____

HIPAA PRIVACY ACT FORM

Release of information for Reimbursement. To the extent necessary to obtain reimbursement, the Facility may disclose any portion of the patient's record including, but not limited to, insurance companies, healthcare service plans, workers compensation carriers, social security administration, and peer review organizations.

Financial Agreement: The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, he/she herby individually obligates himself/herself to pay the account of the facility in accordance with regular rates and terms of the Facility. Should the account be referred to an attorney or collection agency for collection, the undersigned shall pay actual attorney's fees and collection expenses. All delinquent accounts shall bear interest at the legal rate.

Assignment of insurance benefits: The undersigned authorizes, whether he/she signs agent or as patient direct payment to the facility of any insurance benefits otherwise payable to the undersigned for services rendered as a rate not to exceed the facility's usual and customary charges. It is agreed that the payment to the facility, pursuant to the authorization, by an insurance company Health Care Services plan shall discharge said insurance company Health Care Service Plan of any and all obligations under a policy to the extent of such payment. It is understood by the undersigned that he/she is financially responsible for charges not converted by this assignment

Health Care Service Plans: The Facility has contracted with multiple Health Care Service Plans, It is the undersigned's responsibility to know and verify if the benefits contained in the insurance plan agreed to between the undersigned and his/her Health Care Service to know and verify if the benefits contained in the insurance plan agreed to between the undersigned and his/her Health Care Service Plan limit, reduce or deny coverage of medical services as the Facility, The undersigned agrees that he/she is obligated to reimburse the Facility for any deductible co-payments, coverage penalties, or for any service rendered which is not a covered benefit of his/her Health care Service Plan to the Facility. For non-emergency services if is the patient's responsibility to ensure/his/her Plan authorized the requested services at the Facility. The undersigned agrees that denial of payment for lack of an authorization for non-emergency services will be considered a denial for a non-covered benefit and payable by the undersigned.

The Undersigned acknowledges he/she understands the Notice of Privacy Practice and he/she has received a copy of the Notice of Privacy Practices. The undersigned acknowledges he/she understands the Financial Agreement, Assignment of Insurance benefits Health Care Services Plan obligation and all the other application provisions above and received a copy thereof, and is the patients, the patient's legal representative or is duly authorized as the patient's general agent to execute the above and accepts its terms

_____	_____	_____
SIGNATURE PATIENT	DATE	RELATIONSHIP IF NOT PATIENT