***Dr. Alicia M. Kovach***
Chiropractor
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# Pediatric Health History

## Patient Data

Name ______________________ Date __________ Age _____ Sex: ☐ M ☐ F
Address ______________________ City ______________ State ______ Zip________
Telephone ________________ Date of Birth ___/___/___ Height __________ Weight __________
Social Security # ____________________ Referred By ______________________________

## Current Complaints

Purpose of visit: ______________________________________________
______________________________________________
Have they ever had this same condition? ☐ Yes ☐ No If Yes, When? ________________
List other practioners seen for this condition ______________________________
Have they ever been under chiropractic care? ☐ Yes ☐ No If Yes, When? ______________

## Insurance Information

Insurance Company ______________________ Telephone ______________________
Cardholder's Name ______________________ Relationship to you ________________
Cardholder's SS #__________________ ID # ________________ Group # ____________

## Medical History

Have they been treated for any conditions in the last year? ☐ Yes ☐ No
If yes, please describe ______________________________________________
Date of last physical exam __________________
What medications are they taking and for what conditions. (Please list dosage and amounts, etc) ____________
______________________________________________
Check any of the following conditions your child has suffered from during the past six months:
☐Ear Infections ☐ Scoliosis ☐ Seizures ☐ Chronic colds ☐ Headaches ☐ Asthma / Allergies
☐ Digestive problems ☐ ADD/ADHD ☐ Recurring fevers ☐ Growing / Back Pains ☐ Colic
☐ Bed wetting ☐ Car accident ☐ Temper tantrums ☐ Other ________________
Do they suffer from any condition other than for which you are now consulting us about? ____________
______________________________________________
Family History ______________________________________________
Number of **Antibiotics** your child has taken:

During the past 6 months: __________ Total during his/her lifetime: __________
Number of **Vaccines** your child has taken:
During the past 6 months: __________ Total during his/her lifetime: __________
Number of **Prescription medications** your child has taken:
During the past 6 months: __________ Total during his/her lifetime: __________

Childhood Diseases
Chicken Pox: ☐ Yes ☐ No Age_______
Mumps: ☐ Yes ☐ No Age_______
Rubella: ☐ Yes ☐ No Age_______
Measles: ☐ Yes ☐ No Age_______
Whooping Cough: ☐ Yes ☐ No Age_______
Other: ☐ Yes ☐ No Age_______

## Prenatal History

Were there complications during pregnancy? ☐ Yes ☐ No List: ______________________________
Did you have ultrasounds during pregnancy? ☐ Yes ☐ No Number: ________
Did you use medications during pregnancy / delivery? ☐ Yes ☐ No List: ______________________________
Was there any cigarette / alcohol use during pregnancy: ☐ Yes ☐ No
Location of Birth: ☐ Hospital ☐ Birthing Center ☐ Home
Birth intervention: ☐ Vaginal ☐ Forceps ☐ Vacuum Extraction ☐ Caesarian Section: ☐ Emergency or ☐ Planned?
Were there any complications during delivery? ☐ Yes ☐ No List: ______________________
Genetic Disorders or Disabilities: ☐ Yes ☐ No List: __________________________
Birth Weight: _______ Birth Length: _______

## Authorization for Care of a Minor

I hereby authorize:
Dr. Alicia Kovach and whomever they may designate as assistants to administer chiropractic care as deemed necessary to my ______________________, ____________________________________.
(Indicate relationship of child) (Name of child)

Signed:__________________________________ Witnessed:____________________________________

## Certification and Assignment

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company, and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me, and that I am personally responsible for that payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to examine and treat my conditions as he deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctor for X-rays is for examination only and the X-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all the bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

**Patient's Signature X** __________________________________________ **Date** _______________