PEDIATRIC HISTORY FORM

Patient Name: _____ SS#:_____

Name of Parents/Guardians: _____

Address: _____ City: _____ State:_____ Zip: _____

Home Phone: _____ Work Phone: _____ Email: _____

Birth Date: _____ Sex: _____ Weight: _____ Height: _____ # of Siblings: _____

Race: Native or Alaskan Indian: ____ White:_____ Black:_____ BP: _____/_____

Hispanic or Latino:_____ Non Hispanic or Latino:_____

Who referred you to us: _____

Reason for seeing us: _____

Where is the pain: _____ Rate symptoms 0-10/10: _____

Describe the pain: _____

Other doctors seen for this condition: _____

Prior treatment and outcome: _____

Other health problems: _____

Symptoms: Please check any current or past problems your child has on the list below:

___ Dizziness	___ Allergies	___ Diarrhea	___ Broken bones
___ ADHD	___ Runny nose	___ Poor appetite	___ Sprains/strains
___ Backaches	___ Itchy eyes	___ Poor appetite	___ Hernias
___ Heart condition	___ Rashes	___ Behavioral	___ Neck pain
___ Chronic earaches	___ Unusual moles	___ Poor memory	___ Arm/elbow pain
___ Diabetes	___ Neuritis	___ Insomnia	___ Leg/hip pain
___ Tuberculosis	___ Digestive issues	___ Nightmares	___ Knee/foot pain
___ Hypertension	___ Sinus trouble	___ Bed wetting	___ Growing pains
___ Fever/chills	___ Cough/wheeze	___ Pain urinating	___ Joint pain
___ Frequent colds	___ Chest pain	___ Convulsions	___ Paralysis
___ Scoliosis	___ Arthritis	___ Constipation	___ Muscle pain
___ Blood disorders	___ Headaches	___ Anemia	___ Fainting
___ Stomach aches	___ Asthma	___ Rheumatic fever	___ Rheumatoid Arthr.

___ Other _____

Health History:

Name/Address of pediatrician: _____

Date of last visit: _____

Reason for visit: _____

Medications and conditions being treated: _____

Has your child ever taken antibiotics?: Y/N Condition treated: _____

Has your child ever been injured during contact sports (soccer, football, martial arts)?: Y/N

If yes, describe injury (sprain, broken bone, head trauma…)_____

Has your child ever been involved in a car accident? Y/N Date and injuries: _____

Has your child ever fallen head first (from changing table, bed, stairs…)? Y/N

Other traumas not described above: _____

Prior surgery: Y/N Type and date: _____ Menarche: Y/N Age: _____

Prenatal History

Location of birth: ❍ Home ❍ Birthing Center ❍ Hospital ❍ Stepchild ❍ Adopted

Complications during pregnancy: Y/N List: _____

Ultrasounds during pregnancy: Y/N How many?: _____

Medications during pregnancy/delivery: Y/N List: _____

Cigarette/alcohol use during pregnancy: Y/N

Birth intervention: ❍ Forceps ❍ Vacuum ❍ Caesarian, why?: _____

If vaginal delivery: How long was labor? _____ How long did you push? _____

Complications during delivery: Y/N List: _____

Genetic disorders or disabilities: Y/N List: _____

Is child up to date on vaccinations? Y/N

Birth weight: _____ Birth length: _____ APGAR score: 1 min. _____ 5 min. _____

Gestational Age: _____

Feeding History

Breast fed: Y/N How long? _____ Formula fed: Y/N How long? _____ Type: _____

Introduced to solids at _____ months. Cow's milk at _____ months.

Food/juice allergies or intolerances: Y/N List: _____

Developmental History

Sleep (hrs per night): _____ Naps (number and length): _____ Problems sleeping: Y/N

At what age was your child able to: Crawl: ____ Sit alone: ____ Stand alone: ____ Walk alone: ____ Talk: ____

NOTICE

TO ALL NET, THERAPEUTIC EXERCISE, MASSAGE, AND COLON HYDROTHERAPY CLIENTS

Due to the high demand for the above services, we require a minimum of 24 hours notice to cancel an appointment, or you will be billed the **regular cash session fee.**

These appointments are reserved for you and cannot be rearranged for others awaiting an appointment with short notice of less than 24 hours.

We understand that there are times when exceptions will be necessary. These exceptions will be accepted at the discretion of the practitioners.

Thank you for your cooperation in this matter. The Natural Care Wellness Center Staff.

Signature: _____ Date: _____

Natural Care Wellness Center

6 Seeley Lane
Eliot, ME 03903
207-438-9242

NATURAL CARE WELLNESS CENTER

Dr. Scott Ferreira Dr. Jody Ferreira
6 Seeley Lane
Eliot, ME 03903
Tele# (207)439-9242

INDIVIDUAL PATIENT AUTHORIZATION

Patient's Name: _____ Date: _____

This authorization is to confirm the use or disclosure of protected health information. Please sign below to confirm that you have read and understand these statements.

I authorize the release of my medical records to my family practitioner or other physician. Please list name or names of physician_ _____

I authorize the release of my medical records to my health insurance company for payment of rendered services, if requested.

I authorize release of my medical records to any third party payer including insurance, workman's compensation, attorney, auto insurance, etc, if requested.

I authorize Natural Care Wellness Center to send information to my house concerning birthdays or newsletters, and to leave messages on my home, cell phone or work answering machine, such as appointment times.

Patient's signature: _____

NATURAL CARE WELLNESS CENTER

Dr. Scott Ferreira Dr. Jody Ferreira
6 Seeley Lane
Eliot, ME 03903
Tele# (207)439-9242

PRIVATE PRACTICES ACKNOWLEDGEMENT

I have received the notice of the HIPAA Privacy Practice and I have been provided an opportunity to review it.

Name: _____

Date of Birth: _____

Signature: _____ Date: _____

NATURAL CARE WELLNESS CENTER

Dr. Scott Ferreira Dr. Jody Ferreira

6 Seeley Lane

Eliot, ME 03903

Tel# (207)439-9242

AUTHORIZATION, ASSIGNMENT AND CONSENT TO TREAT

Our office policy requires payment in full for all services rendered at the time of visit unless other arrangements have been made with the business manager. If the account is not paid within 90 days of the date of service and no financial arrangement has been made, you will be responsible for any expenses incurred in collecting your account.

_____ I hereby authorize NATURAL CARE WELLNESS CENTER to bill the insurance company for services rendered on my behalf. The billing of such services are a privilege and not a guarantee of coverage. I further authorize the physician and/or supplier to release any information required to process my insurance claims.

_____ I authorize direct payment to you any sum I now or hereafter owe, by my attorney out of the proceeds of any settlement of my case, and/or by insurance company obligated to make payment to me or you based in whole or part upon the charges made for the services.

_____ I understand that whatever amounts you do not collect from the insurance company and/or attorney, whether it be all or part of what is due, I personally owe and agree to pay you.

I hereby authorize the doctors of NATURAL CARE WELLNESS CENTER and whomever they designate as their assistant or authorized representative to administer chiropractor care, acupuncture or colon hydrotherapy as they deem necessary. We invite you to discuss openly treatment, services, and charges rendered at this office, so that there is mutual agreement and clarity.

i understand the above information and guarantee this form was completed correctly to the best of my knowledge, and understand it is my responsibility to inform this office of any change in my medical status.

Signature: _____ Date: _____

Signature of parent or guardian if Patient is under 18 years of age::

_____ Date: _____