The Wellness Way - Coralville
708 5th Street, Coralville, IA 52241
thewellnessway.com
Online Store Referral Code: 6141

CONFIDENTIAL PEDIATRIC HISTORY FORM

It is our pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To better serve you, please complete the following information. We look forward to working with you! Thank You!

Patient Information

Date _____ Date of Birth _____

Legal Name: First _____ Middle _____ Last _____

Preferred Name: First _____ Middle _____ Last _____

Gender at birth ○ F ○ M Height _____ Weight _____

Name of Parent(s)/Guardian(s) _____

Home # _____ Cell # _____ Work # _____

Address _____

City _____ State _____ Zip _____

Patient Email _____

Emergency Contact _____ Emergency Relation _____ Emergency # _____

How Did You Hear About Us?

○ Current TWW Patient Patient Name _____

○ Social Media Which Platform _____

○ Other _____

Employment Information

Employed ○ Yes ○ No Employer Name _____

Employer Address _____

Employer City _____ Employer State _____ Employer Zip _____

Occupation _____ Work Supervisor _____ Supervisor # _____

Work Duties _____

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Patient Name

Reason for this visit

Describe the reason for this visit

When did this concern begin? _____ Has this concern ☐ Gotten Worse ☐ Stayed Constant ☐ Comes and Goes

Does this concern interfere with? ☐ Work ☐ Sleep ☐ Daily Routine ☐ Other Activities

Briefly Explain _____

Has this concern occurred before? ○ Yes ○ No Briefly Explain _____

Have you seen other doctors for this concern? ○ Yes ○ No

Type of treatment _____

Did an Injury Occur? If yes, complete the following

☐ Work ☐ Automobile ☐ Home ☐ Other Injury Date _____

Injury Origin _____

Describe Discomfort _____

Information Regarding Your Concern

Interfere w/ Activities ○ Yes ○ No Affected Sleep ○ Yes ○ No Frequency _____

Missed Work ○ Yes ○ No Unable to work from _____ Unable to work until _____

Affected Appetite ○ Yes ○ No Explain _____

Reduced Work ○ Yes ○ No Explain _____

Does it Worsen ○ Yes ○ No Explain _____

Weather Affects it ○ Yes ○ No Explain _____

What Aggravates Condition _____

What Improves Condition _____

Received Treatment ○ Yes ○ No Explain _____

X-rays Taken ○ Yes ○ No Explain _____

Pain Level Rating (Scale 1-10, 10 being worst) At its best _____ At its worst _____ Current Level _____

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For cycling females only

Age of first period _____

Are you pregnant? ○Yes ○No

Are you nursing? ○Yes ○No

Are you taking birth control? ○Yes ○No If yes, which one? _____

Do you have regular cycles? ○Yes ○No Menses frequency _____ Length of cycle _____

Do you have missed periods? ○ Yes ○ No

Do you experience painful periods? ○ Yes ○No

Do you have clotting? ○ Yes ○No

Are you menopausal? ○ Yes ○No

Do you have breast implants? ○Yes ○No

How many pregnancies have you had? _____

Have you had any miscarriages? ○ Yes ○ No If yes, How many?_____

How many living children do you have? _____

Social Activity Information

Alcohol	○Daily ○Weekly ○Occasionally ○Never	**Caffeine**	○Daily ○Weekly ○Occasionally ○Never
Diet Food Products	○Daily ○Weekly ○Occasionally ○Never	**Drugs**	○Daily ○Weekly ○Occasionally ○Never
OTC Stimulants	○Daily ○Weekly ○Occasionally ○Never	**Exercise**	○Daily ○Weekly ○Occasionally ○Never
Homemade Food	○Daily ○Weekly ○Occasionally ○Never	**Processed Food**	○Daily ○Weekly ○Occasionally ○Never
Soft Drinks	○Daily ○Weekly ○Occasionally ○Never	**Tobacco**	○Daily ○Weekly ○Occasionally ○Never
Water	○Daily ○Weekly ○Occasionally ○Never		

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Patient Name

Patient Health History

Previous Chiropractic Care ○ Yes ○ No Date of Last Adjustment _____

Reason _____

Last Physical Exam _____ Primary Physician _____ Physician Phone _____

Physician City _____ Physician State _____ Physician Zip _____

Health Conditions _____

Broken Bones ○ Yes ○ No Treatment ○ Yes ○ No Explain _____

Sprains/Strains ○ Yes ○ No Treatment ○ Yes ○ No Explain _____

Hospitalized ○ Yes ○ No Explain _____

Surgery ○ Yes ○ No Explain _____

Auto Accident ○ Yes ○ No Explain _____

Struck Unconscious ○ Yes ○ No Explain _____

Eating Disorder ○ Yes ○ No Explain _____

Stroke ○ Yes ○ No Explain _____

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e. a bed, changing table, down stairs, etc.). Was this the case with your child? ○ Yes ○ No If yes, please explain _____

_____

_____

Is/has your child been involved in any high impact or contact sports (i.e. soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.). ○ Yes ○ No If Yes, Please list _____

_____

Patient Medications/Vaccinations/Supplements:

Current Medications (prescribed or over-the-counter) _____

_____

Number of doses of antibiotics your child has taken

During the past six months _____ Total during his/her life _____

Vaccination history _____

_____

Vaccine reactions or side effects _____

_____

Current supplements _____

_____

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Patient Name

Patient Health History (continued)

- [ ] ADHD
- [ ] Alcoholism
- [ ] Allergies
- [ ] Anemia
- [ ] Arteriosclerosis
- [ ] Arthritis
- [ ] Asthma
- [ ] Autoimmune Disease:

_____

- [ ] Back Pain
- [ ] Bed Wetting
- [ ] Bleeding Disorders
- [ ] Breast Lump
- [ ] Bronchitis
- [ ] Bruise Easily
- [ ] Bypass Surgery
- [ ] Cancer
- [ ] Cataracts
- [ ] Chest Pain
- [ ] Chicken Pox
- [ ] Chronic Colds
- [ ] Cold Extremities
- [ ] Colic
- [ ] Congestive Heart Failure
- [ ] Constipation
- [ ] COPD/Emphysema
- [ ] Coronary Artery Disease
- [ ] Cramps
- [ ] CVA (Stroke/Transient Ischemic Attack)
- [ ] Dementia/Alzheimer's
- [ ] Depression
- [ ] Diabetes
  - ○ Type I ○ Type II ○ Juvenile
- [ ] Diagnosed Emotional/Mental
- [ ] Digestion Problems
- [ ] Dizziness
- [ ] Ear Infections
- [ ] Epilepsy
- [ ] Excessive Menstruation
- [ ] Eye Pain or Difficulties
- [ ] Fatigue
- [ ] Frequent Urination
- [ ] Gallbladder Disease/Stones
- [ ] Glaucoma
- [ ] Gout
- [ ] Growing Pains
- [ ] Headache
- [ ] Hemorrhoids
- [ ] Hormone Replacement
- [ ] Hot Flashes
- [ ] Hypertension
- [ ] Irregular Heart Beat
- [ ] Irregular Menstrual Cycle
- [ ] Irritable Bowel Syndrome (IBS)
- [ ] Kidney Infection
- [ ] Kidney Stones
- [ ] Liver Disease/Cirrhosis
- [ ] Loss of Balance
- [ ] Loss of Memory
- [ ] Loss of Smell
- [ ] Loss of Taste
- [ ] Lung Disease
- [ ] Macular Degeneration
- [ ] Measles (Rubeola)
- [ ] Migraines
- [ ] Myocardial Infarction (Heart Attack)
- [ ] Nosebleeds
- [ ] Pacemaker
- [ ] Parkinson's
- [ ] Polio
- [ ] Poor Posture
- [ ] Prostate Trouble
- [ ] Reflux
- [ ] Recurring Fevers
- [ ] Retinal Disease
- [ ] Rubella
- [ ] Sciatica
- [ ] Scoliosis
- [ ] Seizures
- [ ] Shortness of Breath
- [ ] Sinus Infection
- [ ] Skin Sensitivity
- [ ] Sleep Problems/Insomnia
- [ ] Smoker
- [ ] Spinal Curvatures
- [ ] Stroke
- [ ] Swelling of Ankles
- [ ] Swollen Joints
- [ ] Temper Tantrums
- [ ] Thyroid Condition
- [ ] Tuberculosis
- [ ] Ulcers
- [ ] Varicose Veins
- [ ] Venereal Disease
- [ ] Whooping Cough
- [ ] Other: _____

_____

_____

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Patient Birth & Feeding History

Name of obstetrician/midwife _____ Pediatrician / Family MD _____

Did patient's mother...

Have ultrasounds during pregnancy? ○ Yes ○ No If yes, how many? _____

Have medications during pregnancy/delivery? ○ Yes ○ No If yes, please list _____

Use cigarettes or alcohol during pregnancy? ○ Yes ○ No If yes, how much and how often? _____

Have birth intervention? ○ Forceps ○ Vacuum extraction ○ Caesarian section

Have an emergency or planned delivery? ○ Yes ○ No

Was patient breastfed ○ Yes ○ No If yes, how long? _____

Was patient formula-fed ○ Yes ○ No If yes, how long? _____

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

Food/juice allergies or tolerances ○ Yes ○ No If yes, please list _____

Other allergies or tolerances ○ Yes ○ No If yes, please list:_____

Number of hours sleeping per night _____ Quality of sleep: ○ Good ○ Fair ○ Poor

Family Health History

Mother	○ Living	○ Deceased	Cause of Death _____
Maternal Grandmother	○ Living	○ Deceased	Cause of Death _____
Maternal Grandfather	○ Living	○ Deceased	Cause of Death _____
Father	○ Living	○ Deceased	Cause of Death _____
Paternal Grandmother	○ Living	○ Deceased	Cause of Death _____
Paternal Grandfather	○ Living	○ Deceased	Cause of Death _____

Insurance Information

Please provide a copy of your driver's license and insurance card(s).

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Patient Name

Terms of Acceptance

I certify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to The Wellness Way Clinics. I authorize The Wellness Way and it's staff to examine and deliver care as they see fit. I thereby authorize The Wellness Way to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. Verifying insurance benefits does not guarantee payment from my insurance company. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that there is a 48 business hour cancellation policy for new patient and consultation appointments. Failure to comply with the cancellation policy may result in additional charges. A $25 fee will be applied to all NSF checks. By signing below, I agree to the financial policy described above and will adhere to all of it's practices.

Signature _____ Date _____