WELCOME TO BEDFORD HILLS FAMILY CHIROPRACTIC, PC

The purpose of this office is to educate as many families as possible about the spinal condition known as Vertebral Subluxations. Vertebral Subluxations damages an optimally functioning spine and nervous system. This impairs your ability to have optimal health. Your experience with this office will not be only be of healing, but also of learning more about **Optimal Health and Healing.**

PEDIATRIC PATIENT INFORMATION

Print Full Name_____ Today's Date _____

Street Address_____ City _____ State_____ Zip _____

Age _____ Date of Birth _____ Social Security # _____ Height _____ Weight _____

Names of Parents/Guardian: _____ Ages of Siblings_____

Home phone (_____) _____ Cell Phone (_____) _____ Business Phone (____) _____

E-mail address _____ Best Way to Contact you _____

Emergency contact (name-Relationship)_____ (Where they could be reached) _____

Whom may we thank for referring you to our office? _____

Or were you referred by □ Insurance Co. □ Our Website □ By our Location □ Found us in the Phone book

Insurance Co. _____ Policy #_____ Policy Holder_____

REASON FOR SEEKING CHIROPRACTIC CARE

Purpose For Contacting Us? _____

Other Doctors Seen for this Condition: YES / NO. Doctors' Names and Prior Treatments: _____

_____

Other Health Problems? _____

Check any of the following conditions your child has suffered from during the past six months:

□ Ear Infections	□ Asthma/Allergies	□ Colic	□ Scoliosis	□ Digestive Problems
□ Bed Wetting	□ Seizures	□ ADHD	□ Car Accident	□ Chronic Colds
□ Recurring Fevers	□ Headaches	□ Growing Pains		□ Temper tantrums / Mood altered
□ Difficulty Sleeping	□ Other _____			

Family History _____

Previous Chiropractic Care YES/ NO Last Visit:_____ Name of Dr. _____

Name of Pediatrician: _____

Date of Last Visit: _____ Reason & treatment/prescriptions:_____

_____

# of Prescriptions that your child has taken: During the past 6 mo _____ Total During his/her lifetime _____ List _____

Vaccination History: _____

Pre Natal History

Name of Obstetrician or Midwife: _____

Location of Birth _____ Circle One: Hospital / Birthing Center / Home

How was the birth? _____ Any Complications? _____

Check all that apply ___ Vaginal ___ C-section ___ Emergency ___ Planned ___ Forceps used ____Vacuum Extraction

Any Meds During Pregnancy / Delivery? YES/NO List _____ Birth Weight & Length _____

Feeding History

Breast Fed YES/ NO , How Long _____ Formula Fed YES/ NO , How Long _____ Intro to Solids: _____ Months

Food / Juice Allergies Intolerances: YES/ NO , List _____

Developmental History

During your child's development their spine is most vulnerable to stress and regular check ups by a Doctor of Chiropractic are for the prevention and early detection of stresses on their growing spine and nervous system. Did you notice any differences, difficulties or may have skipped some of the following stages:

____ Response to Sound ____ Hold Head Up ____ Sit Up ____ Rolling over ____ Walking Alone

____ Response to Visual ____ Cross Crawl ____ Stand Alone ____ Cruising ____ Feeding themself

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

Is / has your child been involved in any high impact or contact type sports (i.e. Soccer, Football, Gymnastics, Lacrosse, Cheerleading, Martial Arts, Etc)? YES/ NO, List _____

Has your child ever been involved in a car accident? YES/ NO , List _____

Has your child ever been seen on a Emergency Basis YES/ NO , List _____

Prior Surgery: YES/ NO, List _____

Childhood Diseases:

Chicken Pox Yes/No Age ____ Measles Yes/No Age ____ Mumps Yes/No Age ____ Rubella Yes/No Age ____
Whooping Cough Yes/No Age ____ Other Yes/No Age ____ Describe _____

Authorization for Care of Minor:

I hereby authorize this office and its Doctors to administer care to my son/daughter as they deem necessary, I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Name of Parent/Guardian _____ Signature:_____ Date _____

FINANCIAL INFORMATION

Payment in full is expected on all FIRST VISIT services. All other fees are to be paid at time of service unless other arrangements have been made and agreed upon in writing. Please indicate your method of payment. ❑ Cash ❑ Check ❑ Credit Card

Please read the following and sign below.

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 my 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 I am personally responsible for payment. I also understand that if I suspend or terminate my treatment, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to examine and treat my condition 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 the office, being on file where they may be seen at any time while I am an active patient in this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions not for any medical diagnosis. Patient may obtain copies of their file upon request. Copying fees may apply.

The information I have provided, on this case history form, is true and accurate, to the best of my knowledge. I give Dr. Stuart Weitzman permission to render care to me today. This initial visit includes a health history/consultation, chiropractic exam/evaluation, and any initial care that is determined to be clinically necessary and mutually agreed upon.

*Signature*_____ *Today's Date*_____

*Signature of Parent (for minor):*_____ *Today's Date*_____

Thank you for choosing Dr. Stuart Weitzman of Bedford Hills Family Chiropractic.

We look forward to helping you develop a healthier spine and nervous system and *express your life to the fullest*.