SCATKO FAMILY CHIROPRACTIC

1873 Lincoln Hwy East
Lancaster, PA 17602
T: 717-690-2169
F: 717-690-2163

# PEDIATRIC NEW PATIENT FORM

Patient's Name_____ Date_____

Age_____ Date of Birth_____

Parent/Guardian Name_____ Relationship to Patient_____

Address_____ City_____

State_____ Zip_____ Home Phone_____

Cell Phone_____ Email_____

Preferred method of contact? (circle) Home Phone Cell Phone Email

## CHIEF COMPLAINT

What is the main reason that you are seeking care for your child? Please list any injuries, accidents, trauma, or illnesses that are related to this complaint:

_____
_____
_____
_____

Where does your child complain of pain or discomfort?

_____

How often is your child experiencing these symptoms?

_____

When is it worse & better? _____

Have you given them anything for relief? _____

Has your child seen anyone else for this condition? _____

Has your child ever had chiropractic care before? _____

**Birth & Prenatal History: Please Circle Your Answers**

Birth Place: Home Hospital Birth Center Midwife

Type of Delivery: Vaginal C-Section

Interventions: Forceps Vacuum Extraction Epidural

SCATKO FAMILY CHIROPRACTIC

1873 Lincoln Hwy East
Lancaster, PA 17602
T: 717-690-2169
F: 717-690-2163

Complications during delivery:_____

Medications during delivery: _____

If breast fed, did the child nurse equally on both sides? Yes No

**Health History:**

Any allergies or intolerance to foods, medications, etc.?

_____

Vitamins or supplements? _____

Prescription Medications? _____

Has your child ever been hospitalized? If yes, please explain:

_____

Has your child ever had surgery? _____

**Circle any of the follow that your child has had in the past or currently has:**

Ear infections Allergies Colic Psoriasis Bedwetting Scoliosis

Chronic colds Asthma Eczema Diabetes Seizures Fever

Visual Impairments ADD/ADHD Digestive Problems Growing Pains

Headaches Back Aches Chicken Pox Rubella Rubeola Mumps

Measles 5th Disease Hand, Foot & Mouth Disease Whooping Cough

Other:_____

Has your child been immunized? Yes No

Any reactions to an immunization? _____

Other information that you would like us to know about your child that may help us understand their health history, habits, and complaints?

_____

_____

_____

SCATKO FAMILY CHIROPRACTIC

1873 Lincoln Hwy East
Lancaster, PA 17602
T: 717-690-2169
F: 717-690-2163

# Authorization to treat a Minor:

I, _____ the undersigning parent/guardian having legal custody/guardianship of _____, a minor, do hereby authorize, request, and direct the doctors at Scatko Family Chiropractic PLLC to perform in good judgment any examination, chiropractic diagnosis, and treatment which is deemed necessary. I understand that I may ask questions at any time.

**Privacy Verification (Please check if you AGREE to the statement)**

❑ I understand that I may request a copy of the Privacy Policy at any time and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

**Permission to Contact** ❑ I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.

**Payment Verification** ❑ I acknowledge that full payment is due at the time of service and I am responsible for any fees acquired from returned checks. I acknowledge that a 24-hour notice is required to cancel or reschedule an appointment and that I may be charged $25 if such notice is not given. I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

**General Verification** ❑ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

I acknowledge that I have had the opportunity to review the Notice of Privacy Practices on the date below on behalf of Scatko Family Chiropractic, PLLC.

Printed name of Patient_____

Printed name of Parent/Guardian_____

Signature of Parent/Guardian _____ Date_____

Doctor Use Only:

Height: _____ Weight:_____