Ethnicity: Hispanic or Latino/ Other **Preferred Language**: ______________________

Race: Asian/ African Am. / Am. Indian or Alaskan Native/
Other/ Native Hawaii or Pacific Island/ White

Name of Pediatrician: ___________________________ Date of Last Visit: ________________________
Current Medications & Vitamins: ____
Past Trauma (falls, sports injuries, accidents, etc.) ________________________________
Past Surgeries: ____

Prenatal History
Location of Birth: ___ Home ___Birthing Center ___Hospital
Complications during pregnancy: Y-N List:
____
Medications during pregnancy/delivery: ____________________________________
Cigarette/ Alcohol use during pregnancy: Y-N
Birth intervention: ___ Forceps ___ Vacuum ___Caesarian
Complications during delivery: Y-N List:
____
Birth Weight________________ Birth Length________________

Feeding History
Breast Fed: Y-N How long? ___________ Formula Fed: Y-N How long? ___________ Type:
____
Introduced to cereal at ____ months. Solids at ____ months. Cow's milk at ____months
Food/juice allergies or intolerances Y-N List: ______________________________

Developmental History
Sleep (Hrs per night) _________ Problems sleeping ______________________
Medical/Vaccination History

Has your child ever had an adverse reaction to a prescription or over-the-counter medication? Y-N
If yes, please
Explain:
____
Has your child been vaccinated? Y-N Adverse reactions to any
Vaccine? ______________________________

Childhood Disease
___Chicken Pox: Age ____* ___ Mumps: Age ____* ___Rubella: Age ____* ___ Whooping cough: Age ____
___ Measles: Age ____* ___Meningitis: Age ____* ___ Tuberculosis: Age ____* ___ Other: Age ____

Consent For Treatment of Minor

I hereby certify the information I have provided is correct and accurate, to the best of my knowledge.
I, ___________________________, as the parent/guardian of this child, ___________________, hereby grant permission for my child to receive examination and chiropractic treatment as deemed necessary.

______________________________________ ____________________
Signature of Parent or Guardian Date

PEDIATRIC PATIENT INTRODUCTION CARD

Date: ___________

Child's Name: ______________________ Age: _________ Date of Birth: ________________ Sex: M F
Street Address: ____ City, ST, Zip: ____________________
Parent's Names: ____________________________________
Phone: ____ Email: ______________________________________
Whom may we think for referring you to our office? ____
Name of Person Responsible for the Account: ____
Relationship to Patient: _____________________________ Preferred Phone #: ______________________
Address (if different than above): ____
Insurance Company: ___________________________ Name of Insured: ____________________________
Relationship to Patient: ________________________ Date of Birth: ___________________________________

Present Health Challenge(s)

For what health challenge(s) is your child here for? When did it begin?
____

Has your child seen other health care practitioners for this? What did they recommend?
____

What was the outcome of prior treatment/recommendations?
____

Is this dysfunction getting progressively worse? _______ Yes ________ No

Health History

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

__Anemia
__Arthritis
__ADHD
__Allergies
__Anxiety
__Arm/Elbow Pain
__Asthma
__Autism
__Backaches
__Behavioral Issues
__Bed wetting
__Blood disorders
__Broken bones: ______________
__Chest Pain
__Chronic Earaches
__Colic
__Concussions
__Constipation
__Convulsions
__Cough/Wheeze
__Diabetes
__Diarrhea
__Digestive Problems
__Dizziness
__Eczema
__Fainting
__Fever/Chills
__Frequent Colds
__Growing Pains
__Headaches
__Heart Condition
__Hernias
__Hyperactivity
__Hypertension
__Joint Pain
__Insomnia
__Itchy Eyes
__Knee/Foot Pain
__Leg/Hip Pain
__Muscle Pain
__Neck Pain
__Nightmares
__Poor Appetite
__Poor Memory
__Rashes
__Reflux/Spitting up
__Runny nose
__Scoliosis
__Sinus Trouble
__Sprains/Strains
__Stomach Aches
__Unusual Moles
__Other ____________

Runnels Chiropractic, L.L.C.

Authorization and Release

I authorize payment of insurance benefits directly to Dr. Steven K. Runnels or Runnels Chiropractic, LLC. I authorize Runnels Chiropractic, LLC to release any information pertinent to my case to any insurance company, adjusters, and/or attorney involved in the case, I hereby release Runnels Chiropractic, LLC of any consequence thereof. I agree to be financially responsible for all charges incurred at Runnels Chiropractic, LLC including my insurance deductible, co-payment, and any other services rejected by my insurance company. Any account unpaid after 30 days of the date of service shall bear interest at the rate of 16% per month. Should it become necessary to resort to collections, the patient shall be responsible for all costs of collections including a reasonable attorney's fee.

Insurance: Yes____ No____ Company:____

Patient's Signature:____ Date:_________________

Guardian's Signature:____Date:_________________

Clinical Summary Report (CCR)

I understand that a clinical summary report is created after each visit for the purpose of EHR and is available for my review. At this time, I am asking Runnels Chiropractic to save these electronically for me and not print them out after each visit. I understand that, upon request, these reports are available to be printed or emailed to me for review.

Patient's Signature:____Date:_______________