Chiropractic Case History/Patient Information -Minor

Date:_____ Patient #_____ **Dr. Hielscher DC**

Patient name:_____ Social Security #_____

Address:_____City:_____ State:_____ Zip:_____

Age:_____ Birth Date:_____ Race:_____ Home Phone: _____

Parent/Guardian Name:_____ Email:_____

E-mail address:_____ Cell Phone:_____

How were you referred to our office?_____

Family Medical Doctor:_____

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office?_____

Please check any and all insurance coverage that may be applicable in this case**:**

Major Medical Worker's Compensation Medicaid Medicare Auto Accident
Medical Savings Account & Flex Plans Other

Name of Primary Insurance Company:_____
Name of Secondary Insurance Company (if any):_____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

Permission for communication:

Norco Chiropractic values secure, effective and efficient communication. At any time during your care here, we may contact you via phone, email, text and may have a need to leave a voicemail. Please let us know if there is/are any forms of communication that we mentioned that you wish for us NOT to utilize with you.
Please do not contact me via the following:_____

Patient's Signature:_____ Date:_____

Guardian's Signature Authorizing Care:_____ Date:_____

Name:_____ Date:_____

Dr. Hielscher DC

HISTORY OF PRESENT AND PAST ILLNESS:

Chief Complaint: Purpose of this appointment:_____

Date symptoms appeared, or accident happened:_____

Is this due to: Auto___ Work____ Other_____

Have you ever had the same or a similar condition? Yes No If yes, when and describe:_____

_____

Please check health complaints your child is currently experiencing or has experienced in the last six months.

___ Asthma ___Headache ___Ear infection ___Colic ___Allergies ___Bed wetting

___ADHD ___Chronic colds ___Digestive problems ___Scoliosis ___Seizures ___Car accident

___Neck pain ___Back pain ___Other pain

Additional parent comments about child's health status _____

_____

Pregnancy normal? ___Yes ___No Explain: _____

Birth complications? ___Yes ___No Explain:_____

Delivery: ___Home ___Hospital Complications:_____

What prescriptions of antibiotics has your child taken in the past six months: _____

What other medications has your child taken over the past six months:_____

Please list all medications and supplements your child is currently taking:_____

_____

What sports/activities does your child participate in:_____

Family History: please list any family members who have had any of the following.

ADD/ADHD_____
Alcoholism_____
Genetic Disease_____
Hearing deficiency_____
Allergies_____
Hypertension_____
Arthritis_____
Irritable bowel disease_____
Asthma_____
Learning disability_____
Blood disorder_____
Mental illness_____
Cancer_____
Migraines_____

Cardiovascular disease_____
Obesity_____
Coronary Artery disease_____
Osteoporosis_____
Depression_____
Renal disease_____
Seizure disorder_____
Developmental delay_____
Diabetes_____
Stroke_____
Eczema_____
Thyroid disorder_____
Elevated Lipids_____
Other_____

Please list any surgeries child has had and dates:_____

_____

_____

Pain Drawing

Name:_____ Date:_____

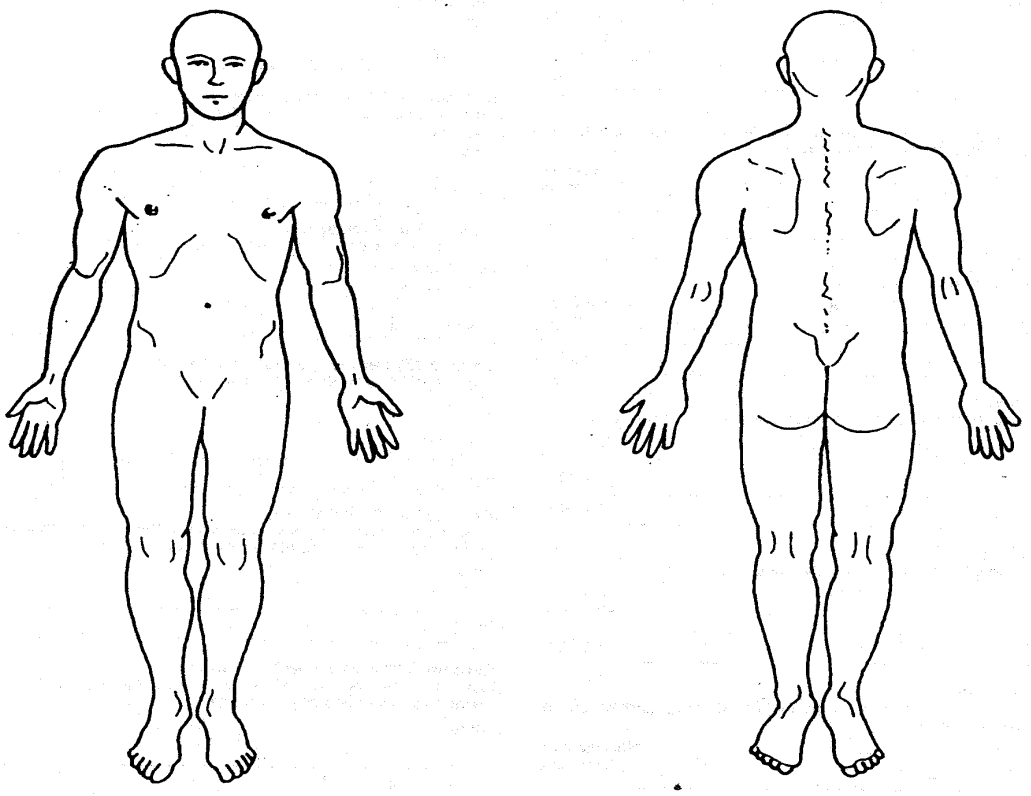
Dr. Hielscher DC

TELL US WHERE YOU HURT.

Please read carefully:

Mark the areas on your body where you feel your pain. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbol(s) listed below.

Ache > > > > > Numbness = = = = = = Pins & Needles o o o o
Burning x x x x Stabbing / / / / / Throbbing ~ ~ ~ ~ ~ ~



0=No pain, 10=most severe pain

What is your current pain level: _____/10

What is your average pain level: _____/10

What is your worst pain level: _____/10

What is your lowest pain level: _____/10

About You

What are your hobbies?

_____
_____
_____
_____

What are your Goals for care? Check what applies.

☐ Come as I please for pain relief

☐ Commit to a care plan to correct my problem(s)

☐ Maintenance care

Norco Chiropractic wishes to help as many people as possible to feel better, be able to do what they want and to be a resource and a healthcare provider that can be a trusted part of your team. We wish not to force any specific care on anyone and understand that healthcare is a personal choice that is influenced by time, money, pain, disability, convenience and lifestyle.

Dr. Wes' Promise to You

It is my mission to thoroughly exam and diagnose you, to educate you on your problem(s), to illustrate what your options of care are and to help you understand what you need. I will be here for any level of care you decide to receive and promise not to abuse the privilege of being one of your Doctors. Please feel free to communicate anything to me that is on your mind, ask questions and be involved in your health with me.

I certify the information provided is accurate to the best of my knowledge:

Name of Patient _____

Signature of Patient/Legal Guardian _____

Date _____