



1767 West Ogden Ave., Ste. 143
Naperville, IL 60540
(630) 355-8988

Pediatric History

Child's Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Parent(s)/Guardian Name(s): _____ Parent's Email: _____

H. Phone:() _____ Cell Phone:() _____

How did you hear about us? _____

Height (of child): _____ Weight: _____ Birth Date: _____ Age: _____ Sex: _____

Siblings and ages: _____

Have you ever received Chiropractic Care? YES NO If yes, approximate date of last visit? _____

Primary reason for visit

Has your child been experience any of the following conditions in the past 6 months?

- | | | |
|---|--|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Frequent Diarrhea | <input type="checkbox"/> Failure to Thrive/Slow Weight Gain |
| <input type="checkbox"/> Respiratory Tract Infections | <input type="checkbox"/> Constipation | <input type="checkbox"/> Slow or Absent Refluxes |
| <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Flatulence | <input type="checkbox"/> Asymmetrical Crawling or Gait |
| <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Headaches/migraines | <input type="checkbox"/> Weight Challenges |
| <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Bed Wetting |
| <input type="checkbox"/> Strep Throat | <input type="checkbox"/> Torticollis/Head Tilt | <input type="checkbox"/> Sleep Problems |
| <input type="checkbox"/> Frequent Colds/Croup | <input type="checkbox"/> Trouble Feeding on One Side | <input type="checkbox"/> Night Terrors |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Growing/Back Pain | <input type="checkbox"/> Tip Toe Walking |
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Lactation/Latching Issues | <input type="checkbox"/> Sensory Processing Issues |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Food Sensitivities | <input type="checkbox"/> Red, Swollen, Painful Joint | <input type="checkbox"/> Tremors/Shaking |
| <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Colic | <input type="checkbox"/> ADD/ADHD |
| <input type="checkbox"/> Recurrent Fevers | <input type="checkbox"/> Frequent Crying Spells | <input type="checkbox"/> Autism/PPD |

Name of Pediatrician: _____ Date of last visit: _____

Reason: _____

Vaccination History: _____

Prenatal History

Name of Obstetrician/Midwife: _____

Complications During Pregnancy? _____ NO _____ YES; list _____

Medications During Pregnancy/Delivery? _____ NO _____ YES; list _____

Cigarette/Alcohol Use During Pregnancy? _____ NO _____ YES

Location of Birth? _____ Hospital _____ Birthing Center _____ Home

Birth Intervention: _____ Forceps _____ Vacuum Extraction _____ Caesarian Section

Complications During Delivery? _____ NO _____ YES; list _____

Genetic Disorders or Disabilities: _____ NO _____ YES; list _____

Birth Weight: _____ Birth Length: _____

Feeding History

Breast Fed: _____ NO _____ YES; How long? _____

Formula Fed: _____ NO _____ YES; How long? _____

Introduced to Solids at _____ months Introduced to Cow's Milk at _____ months

Food/Juice allergies or sensitivities? _____ NO _____ YES; list: _____

Developmental History

At what age was your child able to:

_____ Respond to Stimuli _____ Respond to Visual Stimuli _____ Hold Head Up

_____ Sit Up _____ Crawl _____ Stand Alone _____ Walk Alone

Has your child had a head-first fall? _____ NO _____ YES; when _____

Has your child ever been involved in a car accident? _____ NO _____ Yes; when _____

Other traumas not described above? _____ NO _____ Yes; list: _____

Prior Surgery? _____ NO _____ Yes; list: _____

Any other questions or concerns about your child and their care?

I hereby authorize Advanced Health of Naperville, its Doctors and Staff to administer chiropractic care to my son/daughter as they deem necessary.

Patient Signature

Date

**Advanced Health of Naperville
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Insurance Information:

Do you have health insurance? Yes No Auto Accident? Yes No

Advanced Health of Naperville will gladly accept most health and accident insurance plans and submit the necessary forms/claims required. I authorize payment of medical benefits to Advanced Health of Naperville and/or Dr. Cathy Subber. I authorize release of any medical or other information needed to process claims for services rendered. We will not release any information to any other party.

Name of Parent/Guardian: _____ Date _____

Parent's Signature: _____

Cancellation Policy:

At AHN, we are extremely mindful of valuing the time of each patient that walks through our doors. We only ask that you respect our time in return. Due to an increased number of patients not showing up for scheduled physical therapy sessions; there will be a cancellation policy. "No showing" for appointments not only affects us, but it also denies other patients the opportunity to benefit from the therapy. This change only affects people unwilling to notify us that they would be unable to show up for their scheduled service. We are always happy to help reschedule and/or cancel a scheduled appointment. **Please reschedule/cancel appointments 24 hours prior to your scheduled appointment time.** There will be \$25 fee for "no showing" to either 30 minutes of physical therapy. Please see front desk staff for more information.

Parent/Guardian Signature _____ Date _____

Please acknowledge that you have received the Notice of Privacy Practices from Dr. Cathy Subber, D.C.

Patient/Guardian Signature _____ Date _____