advanced health OF NAPERVILLE

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?

O Asthma
O Respiratory Tract Infections
O Sinus Problems
O Ear Infections
O Tonsillitis
O Strep Throat
O Frequent Colds/Croup
O Eczema
O Rashes
O Allergies
O Food Sensitivities
O Digestive Problems
O Recurrent Fevers

O Frequent Diarrhea
O Constipation
O Flatulence
O Headaches/migraines
O Neck Pain
O Torticollis/Head Tilt
O Trouble Feeding on One Side
O Growing/Back Pain
O Lactation/Latching Issues
O Scoliosis
O Red, Swollen, Painful Joint
O Colic
O Frequent Crying Spells

O Failure to Thrive/Slow Weight Gain
O Slow or Absent Refluxes
O Asymmetrical Crawling or Gait
O Weight Challenges
O Bed Wetting
O Sleep Problems
O Night Terrors
O Tip Toe Walking
O Sensory Processing Issues
O Seizures
O Tremors/Shaking
O ADD/ADHD
O Autism/PPD

Name of Pediatrician: _____ Date of last visit: _____

Reason: _____

Vaccination History: _____

Prenatal History

Name of Obstetrician/Midwife: _____

Complications During Pregnancy? YES NO If yes, please list _____

Medications During Pregnancy/Delivery? YES NO If yes, please list _____

Cigarette/Alcohol Use During Pregnancy? YES NO

Location of Birth? Hospital Birthing Center Home

Birth Intervention: Forceps Vacuum Extraction Caesarian Section

Complications During Delivery? YES NO If yes, please list _____

Genetic Disorders or Disabilities: YES NO If yes, please list _____

Birth Weight: _____ Birth Length: _____

Feeding History

Breast Fed: YES NO How long? _____

Formula Fed: YES NO How long? _____

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

Food/Juice allergies or sensitivities? YES NO If yes, please 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? YES NO If yes, when _____

Has your child ever been involved in a car accident? YES NO If yes, when _____

Other traumas not described above? YES NO If yes, please list: _____

Prior Surgery? YES NO If yes, please 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_____

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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 _____