PEDIATRIC HISTORY FORM – Sulack Health & Wellness, PLLC

Who can we thank for referring you to our office _____

PATIENT DEMOGRAPHICS HR#:_____

Child's Name_____ Today's Date _____ /_____ /_____

Date of Birth _____ /_____ /_____ Birth Height: _____ Birth Weight: _____

Current Height: _____ Current Weight: _____ Age: _____ Gender: _____

Address _____ City _____ State _____ Zip _____

Phone (Home) _____

Mothers Name: _____ Mother's Mobile _____DOB___/___/___

Fathers name: _____ Father's Mobile_____DOB ___/___/___

Pediatrician/Family MD _____City & State _____ Last Visit: ___/___/___

Reason for last Pediatrician visit:_____

Email Address (Parent): _____ Preferred Pharmacy:_____

Preferred Communication (Circle One): Text - Phone - Email

CHILD'S CURRENT PROBLEM:

Purpose of this visit: Wellness Checkup _____ Injury or Accident _____ Other _____

Please explain: _____

If your child is experiencing ***Pain/Discomfort please identify where and for how long*** _____

_____

1. **When did the** Problem first begin? Date ___/___/_____ Unknown _____ Gradual _____ Sudden _____
2. **Ever had** this problem **before**? No_____ Yes_____ If yes when? _____
3. Any **bowel or bladder** problems since this problem began?: No _____ Yes _____
   If yes *(Describe)*: _____
4. Have you seen any **other doctors** for this problem? No _____ Yes _____ If yes who? _____
5. How long ago? Days _____ Weeks _____ Months _____ Years _____
6. What were the results of past treatment? _____
7. How is this problem **NOW:** ☐ Rapidly Improving ☐ Improving Slowl ☐ About the Same ☐ Gradually Worsening ☐ On & Off
8. Please list any **medication taken** for this problem: _____
9. Has your child ever sustained an injury playing organized sports? No _____ Yes _____ If yes; please explain

   _____
10. Has your child ever sustained an injury in an auto accident? No _____ Yes _____ If yes, please explain

    _____

Child's Name_____ Date_____ HR#_____

HAS YOUR CHILD EVER SUFFERED FROM: *mark "**X**" for all that have occurred*

_ Headaches	_ Orthopedic Problems	_ Digestive Disorders	_ Behavioral Problems
_ Dizziness	_ Neck Problems	_ Poor Appetite	_ ADD/ADHD
_ Fainting	_ Arm Problems	_ Stomach Aches	_ Ruptures/Hernia
_ Seizures/Convulsions	_ Leg Problems	_ Reflux	_ Muscle Pain
_ Heart Trouble	_ Joint Problems	_ Constipation	_ Growing Pains
_ Chronic Earaches	_ Backaches	_ Diarrhea	_ Allergies to_____
_ Sinus Trouble	_ Poor Posture	_ Hypertension	_ Asthma
_ Scoliosis	_ Anemia	_ Colds/Flu	_ Walking Trouble
_ Bed Wetting	_ Colic	_ Broken Bones	_ Sleeping Problems
_ Fall in baby walker	_ Fall from bed or couch	_ Fall from crib	_ Fall off swing
_ Fall off bicycle	_ Fall from high chair	_ Fall off slide	_ Fall down stairs
_ Fall from changing table	_ Fall off monkey bars	_ Fall off skateboard/skates	_ Doing "Sit-ups"
_ Favor left neck rotation	_ Poor Latch-(Nursing)	_ Favor Nursing One Side -Mom's Left)	
_ Favor right neck rotation	_ Often Irritable	_ Favor Nursing One Side -Mom's Right)	

All Medications and Supplements:_____
_____

Known Allergens:_____
_____

I understand that I am directly and fully responsible to Sulack Health & Wellness, PLLC for all fees associated with treatment and care my child receives.

The risks associated with exposure to ionizing radiation and treatment have been explained to me to my complete satisfaction, and I have conveyed my understanding of these risks to the doctor. After careful consideration I do hereby request and authorize imaging studies and treatment for the benefit of my minor child for whom I have the legal right to select and authorize health care services on behalf of.

Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other guardian is not required. If my authority to so select and authorize this care should change in any way, I will immediately notify this office.

_____ _____
Parent or Legal Guardian's Signature Date

Doctor Signature _____ Date_____

Doctor Initials_____

Sulack Health & Wellness, PLLC.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ Date: _____

I acknowledge that I have received the Notice of Privacy Practices of Sulack Health & Wellness, PLLC.. I acknowledge that it is the policy of Sulack Health & Wellness, PLLC to leave reminder messages on my answering machine or with another person in my home. I may make a request of an alternative means of communication (within reason) in writing. I acknowledge that if I should have a problem or question in regard to my rights, I may speak with a privacy officer about my concerns.

(X) _____ _____

Signature of Patient Date

X-RAY QUESTIONNAIRE FOR WOMEN

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Name: _____

- ☐ There is a possibility that I may be pregnant at this time.
- ☐ Yes, I am definitely pregnant
- ☐ No, I am definitely not pregnant
- ☐ I request that x-ray films not be taken because

_____

_____

Date of last menstrual cycle: _____

(X) _____ _____

Patient Signature Date

Dr. Initial: _____