MORETTI CHIROPRACTIC
PREGNANCY, PEDIATRIC, & ADULT CARE

CHILD HISTORY FORM

Date _____

Name_____ Nickname _____

Parent's/Guardian's Name_____ Child's S.S.#_____

Home Address _____

Home Phone_____ Parent's Work_____ Parent's Cell _____

Parent's email _____

Birth Date_____ Age_____ Number of Siblings _____

Referred To This Office By_____

Reason for contacting us?_____

Other Doctors Seen for This Condition_____ Result_____

Pediatrician/Family M.D._____
Name Location

Has this child had previous Chiropractic care? Yes___ No___ If, yes, where? _____

Is your child currently taking any prescription or over-the-counter medications or herbs?
_____

Prenatal History
Name of Obstetrician/Midwife
_____
Problems During Pregnancy_____
Y N Experience any physical trauma (falls or injuries)? _____
Y N Have any ultrasound studies or Doppler-tones? If so, how many?_____
Y N Eat a well-balanced diet? **Y N** Smoke tobacco? **Y N** Drink alcohol?
Y N Take any drugs or medications?_____
Y N Have any emotional trauma or difficulty?_____

Birth Information
Hospital Birth _____ Home Delivery _____ Birthing Center _____
Birth Intervention: Labor Induced_____ Forceps_____ Vacuum Extraction_____
Cesarean ___ Planned **Y N** Breech____ Position_____ Medication during labor **Y N**_____
Was there any 'pulling' by the doctor or midwife? _____
Problems During Labor/Delivery_____
Birth Weight_____ Birth Length_____ Apgar Scores _____
After birth, was there a presence of: Jaundice (Yellow)_____ Cyanosis (Blue)_____
Congenital Anomolies/Defects_____

Feeding History
Infant Feeding and Duration: Breast_____ Formula____ Introduced to Solid Foods at __ months
Introduced to cow's milk at _____ months
Food Allergies _____

Developmental History
During the following times your child's spine is most vulnerable to stress and should routinely be checked by a Chiropractor for early detection and correction of vertebral subluxations (nerve interference) At what age was your child able to:
____ Respond to sound ____ Follow object with eyes ____Hold head up ____ Sit alone
____ Crawl ____ Stand ____ Walk Alone ____ Roll over
This child is: ____ Right handed ____ Left Handed ____ Ambidextrous ____ Not yet known

Accidents/Traumas
According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e., a bed, changing table, down stairs, etc.) Was this the case with your child?_____

Is/has your child been involved with any high impact or contact type sports (soccer, football, gymnastics, baseball, cheerleading, martial arts)?_____

Has your child ever been involved in a car accident?____ Dates_____
Type_____

Has your child ever been seen in the emergency room? _____Reason _____

Other traumas/surgeries not yet described? _____

Childhood Diseases: If any, please indicate at what age:
Chickenpox _____ Mumps _____ Rubella _____ Rubeola _____ Whooping Cough _____
Other_____

Antibiotics prescribed – Number of doses
_____

Other prescription or non-prescription Medication (Tylenol/aspirin/etc.)
During past six months: _____ Total during child's lifetime _____
List them _____
Vaccination History _____

Has your child ever been diagnosed with or suffered from:

___ Ear Infections	___ Headaches	___ Growing Pains	___ Chronic Colds/flu
___ Dizziness	___ Backaches	___ Bed Wetting	___ Scoliosis
___ Fainting	___ Neck Problems	___ Seizures	___ Asthma
___ Allergies	___ Muscle Jerking	___ Arm/Leg Problems	___ Anemia
___ Pneumonia	___ Cancer	___ Joint Problems	___ HIV/AIDS
___ Ruptures/Hernias	___ Broken Bones	___ Poor Appetite	___ Sore Throats
___ Sinus Trouble	___ Skin Problems	___ Diabetes	___ Walking Problems
___ Digestive Problems	___ Numbness	___ Rheumatic Fever	___ Paralysis
___ Colic	___ Behavior Problems	___ Appendicitis	___ Arthritis
___ Constipation	___ Hyperactivity	___ Meningitis	
___ Diarrhea	___ ADHD/ADD	___ Encephalitis	
___ Other			

_____

Family History Have the child's parents, siblings, or grandparents ever experienced problems with any of the following:

___ Diabetes	___ Thyroid Disease	___ Tuberculosis	___Kidney Disease
___ High blood pressure	___ Heart disease	___ Arthritis	___ Cancer

___ Other family history_____

Parent's/Guardian's Signature: _____ Date: _____

8782 Cloverdale Road · Troutville, VA 24175
Phone: 540-992-3354 · www.morettichiropractic.com

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. In the course of your care as a patient at Moretti Chiropractic, we may use or disclose personal and health related information about you in the following ways:
A. Treatment. *Example:* We may use your health information within our office to provide health care services to you or we may disclose your health information to another provider if it is necessary to refer you to them for services.

B. Payment. *Example:* We may disclose your health information to a third party such as an insurance carrier, an HMO, a PPO, or your employer, in order to obtain payment for services provided to you.

We are permitted and may use or disclose your protected health information without your written consent, written authorization or oral agreement under the following circumstances:

- ❑ If we provide services to you in an emergency treatment situation.
- ❑ If we are required by law to provide services to you and we were unable to obtain your consent after attempting to do so.
- ❑ If there are substantial barriers to communication and we determine, in the exercise of our professional judgment, that you intend for us to treat you.
- ❑ If we need to notify, or assist in the notification of, a family member, personal representative or another person responsible for your care of your location, general condition, or death.
- ❑ If we are required by law to disclose your health information to a public health authority that is authorized to receive information for the purposes of preventing or controlling disease, injury or disability.
- ❑ If we are required by law to disclose your health information to a public health or other government authority that is authorized to receive reports of child abuse, neglect, or domestic violence.
- ❑ If we are required to disclose your health information to the Food and Drug Administration.
- ❑ If we are required to disclose your health information in response to a court order or a subpoena or a law enforcement official.
- ❑ If we are required to disclose your health information to a coroner, medical examiner or funeral director.
- ❑ If we, in good faith, believe that the use or disclosure of your health information is necessary to prevent a serious threat to the health or safety of others.
- ❑ I understand Moretti Chiropractic may use my name, address, phone number, and email to contact me with birthday cards, holiday related cards and announcements regarding patient appreciation days and/or other special occasions, and information about treatment alternatives or other health related information. I am also aware that on specific occasions photographs may be taken and posted within the office or placed on our website or Facebook page for others to see.
- ❑ If I have given, or will give in the future, a written testimony as to my health care with Moretti Chiropractic, I give permission to share this information in whatever manner they deem appropriate.
- ❑ If photos and/or videos of my child are taken, I give my permission for these to be used by *Dr. Moses Moretti and Moretti Chiropractic* for educational or marketing purposes, and release *Dr. Moses Moretti and Moretti Chiropractic* and any third party producers of said materials from any legal claims or liability arising from the use of said materials. I may contact Moretti Chiropractic if I wish to withdraw my consent.

Signature _____ Relationship to Patient_____
Patient or Personal Representative/Guardian

Print Name _____ Date _____
Patient Name