Hurst Chiropractic, P.C.

1120 GRANT ROAD EAST WENATCHEE, WASHINGTON 98802 (509) 884-7163 Fax: (509) 884-2363 www.HurstClinic.com

PEDIATRIC CASE HISTORY

File#______________

Child's Name____ Date________

(Last) *(First)* *(MI)* *(Preferred Name)*

Street Address________________________Apt#________City______________State____Zip________

Mailing Address *(if other than above)* Rural Route#________and/or P.O. Box____________City____________

E-mail Address______________________ Would you like to receive our e-mail newsletter? [ ] Yes [ ] No

Home Phone________________Date of Birth____________Age________Sex: Male Female

Father's Name ________________Occupation____________________Employer________________

Mother's Name ________________Occupation____________________Employer________________

Primary Care Physician____________________at______________________________ None

Does your child have Insurance with Chiropractic Benefits? No [ ] Yes [ ]

Subscriber______________________________Subscriber's Date of Birth________________

Subscriber's SS# ____________________Person responsible for account________________

Would you like to receive e-mail communication from our office? [ ] Yes [ ] No

IN CASE OF EMERGENCY:

Relative or friend not living in your home__________________________Phone______________

I clearly understand and agree that I am personally responsible for full payment of all services rendered to my child.

Parent/Guardian's Signature__________________________________

Describe the current symptoms____

____

How did the symptoms begin?____

Is the pain or discomfort worsening? [ ] No [ ] Yes [ ] Same What, if anything, makes it worse?__________

____

Does the condition interfere with? [ ] Sleep [ ] Recreation [ ] Daily Routine ________________

____

Has there been any previous treatment for this condition? Results?____________________

Have any X-rays been taken? No [ ] Yes [ ] ____________________Where?______________

Has a similar problem occurred in the past? No [ ] Yes [ ]______________________________

Any previous spinal injuries? No [ ] Yes [ ]______________________________________

Are any medications currently being taken? No [ ] Yes [ ]____________________________

Any previous surgeries or hospitalizations? No [ ] Yes [ ]____________________________

Any complications during birth? No [ ] Yes [ ] Unknown [ ] ____________________________

Other health issues or history: *(Check all that apply)*______________________________

- ❑ General Fatigue or Weakness
- ❑ Fever (continuous)
- ❑ Loss of Sleep / Trouble Sleeping
- ❑ Headaches
- ❑ Dizziness / Fainting
- ❑ Convulsions
- ❑ Nervousness / Anxiety / Depression / Phobias
- ❑ Memory Loss or Impairment
- ❑ Difficulty Concentrating
- ❑ Nose / Sinus Symptoms
- ❑ Ear pain / Trouble
- ❑ Vision / Eye Trouble
- ❑ Tonsillitis / Infected Tonsils
- ❑ Skin / Nail / Hair changes
- ❑ Heart Trouble or Chest Pain
- ❑ Respiratory / Breathing
- ❑ Change in Appetite
- ❑ Abdominal Pain
- ❑ Nausea/Vomiting
- ❑ Gastrointestinal / Digestion
- ❑ Urinary
- ❑ Allergies____

❑ None of the above-listed symptoms apply. CA/DC Initials __________

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Authorization for Treatment of a Minor

I am the parent or legal representative of_________________________________, who is a minor, ________ months / years of age. I authorize the performance of diagnostic x-ray examination, surface electromyography and thermography scans, and chiropractic treatment to be rendered by Dr. Thomas R. Hurst or Dr. Chad R. Hurst or Dr. Jason Gutzwiler and that the following persons may seek treatment for the above captioned minor in my absence:____

____
Signature

____
Date

HCC –6-12 - Forms/Intake Forms/Authorization to Treat Minor

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Authorization for Treatment of a Minor

I am the parent or legal representative of_________________________________, who is a minor, ________ months / years of age. I authorize that massage therapy be rendered Tiffany Munson, LMP, Sharon Wood, LMP, Caryn Goulden LMP, Lisa Sparks, LMP or Kristen Young, LMP and that the following persons may seek treatment for the above captioned minor in my absence:_____________________________

____
Signature

____
Date

HCC- 6-12
Forms/Intake Forms/Authorization to Treat Minor-LMP and chiro