PEDIATRIC HISTORY FORM

PATIENT DEMOGRAPHICS   HR#:___________________

Today's Date _____/_____/____

Childs Name____

Date of Birth _____/_____/______   Age: _____

Birth Height: _______   Birth Weight: _______   Current Height: ______   Current Weight: _____

Address ____

City _____________________ State _____ Zip __________ Phone (Home) _________________________

Mother's Name: ________________________ DOB____/____/____ Mother's Mobile _______________

Father's Name: ________________________ DOB ____/____/____ Father's Mobile ________________

Pediatrician/Family MD _____________________________________City/State ____________________

Last Visit: ____/____/____ Reason for visit:____

Who is responsible for this bill? ____

☐ Father's Social Security #______-______-______ ☐ Mother's Social Security #______-______-______

☐ Other *(please explain)*: ____

CHILD'S CURRENT PROBLEM:

Purpose of this visit: _____Wellness Check-up   _____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?:   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 Slowly   ☐ 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:

____

____

____

HAS YOUR CHILD EVER SUFFERED FROM: *Check all that apply*

☐ 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	☐ Asthma
☐ Sinus Trouble	☐ Poor Posture	☐ Hypertension	☐ Walking Trouble
☐ Scoliosis	☐ Anemia	☐ Colds/Flu	☐ Sleeping Problems
☐ Bed Wetting	☐ Colic	☐ Broken Bones	☐ Fall off swing
☐ Fall in baby walker	☐ Fall from bed or couch	☐ Fall from crib	☐ Fall down stairs
☐ Fall off bicycle	☐ Fall from high chair	☐ Fall off slide	
☐ Fall from changing table	☐ Fall off monkey bars	☐ Fall off skateboard/skates	

☐ Allergies to____

☐ Other: ____

I understand that I am directly and fully responsible to (Insert Practice or Doctor's Name) for all fees associated with chiropractic care my child receives.

The risks associated with exposure to ionization and spinal adjustments 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 chiropractic adjustments 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's Signature Date