PEDIATRIC HISTORY FORM

PATIENT DEMOGRAPHICS
HR#:_____

Childs Name_____ Today's Date _____/_____/____

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

Current Weight: _____ Age: _____ Address: _____

City _____ State _____ Zip _____ Phone (Home) _____

Mother's Name: _____ Mother's Mobile _____ DOB____/____/____

Father's Name: _____ Father's Mobile _____ DOB ____/____/____

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? _____ If yes; please explain

   _____

   _____

10. Has your child ever sustained an injury in an auto accident? _____ if yes, please explain

_____

_____

HAS YOUR CHILD EVER SUFFERED FROM (Mark a **Y** for yes or **N** for no)

	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		Other: _____

I understand that I am directly and fully responsible to (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 Signature Date

JDD,DC 5/2011