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) _____

Mothers Name: _____ Mother's Mobile _____DOB____/____/____

Fathers name: _____ Father's Mobile _____ DOB ____/____/____

Pediatrician/Family MD: _____ City & State: _____

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

Who is responsible for this bill/finances? _____ Relationship: _____

☐ 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?: [ ] No [ ] Yes**
   If yes, please *Describe*:

_____

_____

4. **Have you seen any other doctors for this problem? [ ] No [ ] Yes**
   If yes who? _____
5. **How long ago did this problem begin?**
   _____ 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: (*Mark* 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
□ 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 off monkey bars	□ Fall from changing table	□ Fall off skateboard/skates	

□ Other: _____
_____

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/CA Signature: _____ **Date**_____