



PEDIATRIC HISTORY FORM

Today's Date:

PATIENT DEMOGRAPHICS

Child's Name: _____ Date of Birth: _____ Sex: M F

Birth Height: _____ Birth Weight: _____ Current Height: _____ Current Weight: _____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Mother: _____ Cell: _____

Father: _____ Cell: _____

Who is responsible for this bill? _____

Who referred you to our office? _____

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? Yes No If yes when? _____

3. Any bowel or bladder problems since this problem began? Yes No

(Describe): _____

4. Have you seen any other doctors for this problem? Yes No If yes who? _____

5. How long ago? _____

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 medications or supplements taken for this problem: _____

9. Has your child ever sustained an injury playing organized sports? Yes No

If yes; please explain _____

10. Has your child ever sustained an injury in an auto accident? Yes No

if yes, please explain _____

HAS YOUR CHILD EVER SUFFERED FROM: check applicable items

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Orthopedic Problems | <input type="checkbox"/> Digestive Disorders | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Neck Problems | <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> ADD/ADHD |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Arm Problems | <input type="checkbox"/> Stomach Aches | <input type="checkbox"/> Reflux |
| <input type="checkbox"/> Seizures/Convulsions | <input type="checkbox"/> Leg Problems | <input type="checkbox"/> Ruptures/Hernia | <input type="checkbox"/> Muscle Pain |
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Joint Problems | <input type="checkbox"/> Constipation | <input type="checkbox"/> Growing Pains |
| <input type="checkbox"/> Chronic Earaches | <input type="checkbox"/> Backaches | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Poor Posture | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Asthma | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Behavioral Problems | <input type="checkbox"/> Colds/Flu | <input type="checkbox"/> Walking Trouble | <input type="checkbox"/> Bed Wetting |
| <input type="checkbox"/> Fall in baby walker | <input type="checkbox"/> Fall from bed or couch | <input type="checkbox"/> Fall from crib | <input type="checkbox"/> Fall off swing |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Colic | <input type="checkbox"/> Fall off bicycle |
| <input type="checkbox"/> Fall from high chair | <input type="checkbox"/> Fall off slide | <input type="checkbox"/> Fall from changing table | <input type="checkbox"/> Fall off monkey bars |
| <input type="checkbox"/> Other: _____ | | <input type="checkbox"/> Allergies to _____ | |

How was the birth?

- Forceps or suction Cord around the neck Drug Induced Cesarean Section Breech

I understand that I am directly and fully responsible to Discover Chiropractic 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