DEIGNAN FAMILY CHIROPRACTIC
PEDIATRIC HISTORY FORM

PATIENT DEMOGRAPHICS

Today's Date: ____/____/_____ Child's Name: _____

Date of Birth: ____/____/_____ Age: ____ Birth Height: ____ Birth Weight: _____

Current Height: _____ Current Weight: _____

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

Mother's Name: _____ Mother's Cell Phone: _____ DOB: __/____/____

Father's Name: _____ Father's Cell Phone: _____ DOB: __/____/____

Home Phone: _____ Email Address: _____

Pediatrician/Family MD:_____City & State: _____

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

Who is responsible for this bill?: _____

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

CHILD'S CURRENT PROBLEM(S):

Purpose of this visit: ☐ Wellness Checkup ☐ 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 Onset ☐ Sudden Onset
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 explain: _____
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:

(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 Ache	☐ 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 from changing table	☐ Fall off monkey bars	☐ Fall off skateboard/skates	☐ Other: _____

I understand that I am directly and fully responsible to Deignan Family 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's Signature Date