Pediatric History Form

Patient Demographics:

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

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

Current Weight: _____ Age: _____ Address: _____

City: _____ State: _____ Zip Code: _____ Phone(Home): _____

Mother's Name: _____ Mother's Phone: _____ DOB: ___ /___ / ___

Father's Name: _____ Father's Phone: _____ DOB: ___ / ___ / ___

Pediatrician/Family MD: _____ City & State: _____

Last Visit: ___ / ___ / ___ Reason for Visit: _____ ?

Who is responsible for the bill: _____?

Father's Social Security Number: _____-_____-_____ Mother's Social Security Number: _____-_____-_____

Other (*please explain*):

Child's Current Problem:

Purpose of the Visit *(please check one of the following):* _____ Wellness Checkup ____ Injury or Accident _____
Other (*please explain*): _____

If your child is experiencing **Pain/Discomfort**, please identify where and how far along_____
_____

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 the problem began? If yes,
   (*Describe*): _____
4. Have you seen any **other doctors** for this problem: No – Yes If yes who, _____
5. How long ago? (*Please Circle One*): Days – Weeks – Months – Years
6. What were the results of the past treatment? _____
7. How is this problem **NOW** (*please circle one of the following*): 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 an organized sport(s)? _____ 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 ANY OF THE FOLLOWING: (please check the appropriate box):

□ 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 Ear Aches	□ 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 from Monkey bars	□ Fall off skateboard	□ Other_____ _____

I understand that I am directly and fully responsible to E.P. True 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 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 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

Informed Consent:

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures

I have been advised that chiropractic care, like all forms of health care, hold certain risks. While the risks are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractor adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at E.P. True Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, methods, and techniques the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ ____/____/____ ☐ *Witness Initials*

Patient or Authorized Person's Signature Date

REGARDING: X-Rays/Imaging Studies

FEMALES ONLY: Please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.

☐ The first day of my last menstrual cycle was on: ____/____/____ Date

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____ ____/____/____ ☐ *Witness Initials*

Patient or Authorized Person's Signature Date