

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 ____ / ____ / ____

Fathers 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?: (Y / N). 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 **Y** for YES or **N** for NO

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Orthopedic Problems | <input type="checkbox"/> Digestive Disorders | <input type="checkbox"/> Behavioral Problems |
| <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 Ache | <input type="checkbox"/> Ruptures/Hernia |
| <input type="checkbox"/> Seizures/Convulsions | <input type="checkbox"/> Leg Problems | <input type="checkbox"/> Reflux | <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"/> Allergies to _____ |
| <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"/> Anemia | <input type="checkbox"/> Colds/Flu | <input type="checkbox"/> Walking Trouble |
| <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Colic | <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Sleeping Problems |
| <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"/> Fall off bicycle | <input type="checkbox"/> Fall from high chair | <input type="checkbox"/> Fall off slide | <input type="checkbox"/> Fall down stairs |
| <input type="checkbox"/> Fall from changing table | <input type="checkbox"/> Fall off monkey bars | <input type="checkbox"/> Fall off skateboard/skates | <input type="checkbox"/> Other: _____ |

I understand that I am directly and fully responsible to **Trinity 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