

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 _____
 Phone (Home) _____ Mother's mobile: _____ Father's mobile: _____
 Mother _____ DOB ____/____/____ Father _____ DOB ____/____/____
 Pediatrician/Family MD _____ City & State _____ Last Visit: ____/____/____
 Do you have health insurance? YES NO Name of Company? _____
 Who is responsible for this bill? Father Social Security # _____ - _____ - _____ Mother 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?: No 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: _____

Has your child ever sustained an injury playing organized sports? _____ If yes, please explain _____

Has your child ever sustained an injury in an auto accident? _____ If yes, please explain _____

Name of Previous Chiropractor: _____ N/A

How long were you under care? _____ What were the results: _____

HAS YOUR CHILD EVER SUFFERED FROM: mark a **Y** for YES OR **N** 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 Aches | <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 Lerner Family Chiropractic Centre for all fees associated with chiropractic care my child receives. It has been explained to me that all fees paid for x-rays taken at this office are for the examination, and that I am only entitled to a copy of the written imaging report, which explains the results of my child's examination. The actual films themselves are considered part of my child's original health record and as such will not be released to anyone, under any circumstances, including me. I further understand and agree that they are **the sole legal property** of this practice and that by law the doctor must retain these films for a period of no less than four (4) years.

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