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 Cell:_____ DOB: _____
Father's Name:_____ Father's Cell:_____ DOB:_____

Pediatrician/Family MD:_____ City & State:_____

Last Visit:_____ Reason for visit:_____

Who is responsible for this bill?:_____

- ☐ Mother's Social Security #:_____
- ☐ Father'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? ___No ___Yes
   If yes*(describe*):_____
4. Have you seen any other doctor 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 the problem now: ___rapidly improving ___improving slowly ___about the same
   ___gradually worsening ___on & off
8. Please list any medications taken for this problem:_____
9. Has your child ever sustained an injury playing organized sports? ___No ___Yes
   If yes *(explain):*_____
10. Has your child ever sustained an injury in an auto accident? ___No ___Yes
    If yes *(explain):*_____

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HAS YOUR CHILD EVER SUFFERED FROM:

☐ 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 earaches	☐ Backaches	☐ Diarrhea	☐ Allergies to_____
☐ 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 of 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 Clark 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 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 the office.

_____ _____

Parent or Legal Guardian's Signature Date

_____ _____

Doctor Signature Date