PEDIATRIC HISTORY FORM

PATIENT DEMOGRAPHICS

HR#:								
	s Name		Todav's [Date /	/			
	of Birth/							
	nt Weight: Age: Addres	_	_	_				
	Zip							
	er's Mobile							
	ers name:			DOB/	/			
Pedia	trician/Family MD		City & State					
Last \	/isit: <u>/</u> /Reason for vi	sit:	-					
	is responsible for this bill?							
□ Fa	ther's Social Security #		ner's Social Security #					
☐ Father's Social Security # ☐ Mother's Social Security # ☐ Other (please explain):								
Pleas	wellness e explain: r child is experiencing pain/discomfo When did the Problem first beging Ever had this problem before? If Any bowel or bladder problems	rt please identify where and fin? Date/ / NoIf yesIf yes	or how long Unknown when?	Gradua	alSudden			
	Have you seen any other doctor	re for this problem? No	Vas If vas who?					
		·						
5. 6	How long ago?Days		Month		Years			
	 6. What were the results of past treatment?							
7.	ı	apidiy improving 🗆 improvii	ing Slowly - About the s	Same Gradually	vvorsering			
•	□On & Off							
8.	Please list any medication taker	•						
9.	Has your child ever sustained a	n injury playing organized s	ports?It yes; p	nease explain				
10.	Has your child ever sustained a	n injury in an auto accident	?if yes, please	e explain				

Parent or Legal Guardian's Signature

Doctor Signature

HAS YOUR CHILD EVER SUFFERED FROM: mark Y for YES or N for NO Orthopedic Problems Digestive Disorders **Behavioral Problems** Headaches Neck Problems Poor Appetite ADD/ADHD Dizziness Arm Problems Stomach Ache Ruptures/Hernia Fainting Leg Problems Muscle Pain Reflux Seizures/Convulsions Joint Problems **Growing Pains** Constipation Heart Trouble Backaches Allergies to Chronic Earaches Diarrhea Asthma Poor Posture Hypertension Sinus Trouble Anemia Walking Trouble Colds/Flu Scoliosis Sleeping Problems Colic **Broken Bones Bed Wetting** Fall from bed or couch Fall off swing Fall from crib Fall in baby walker Fall from high chair Fall off slide Fall down stairs Fall off bicycle Fall off monkey bars Fall off skateboard/skates Other: Fall from changing table I understand that I am directly and fully responsible to this office for all fees associated with chiropractic care my child receives. The risks associated with exposure to x-rays 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. I hereby request and authorize this office to administer healthcare as deemed necessary to my dependent minor child. This authorization also extends to include diagnostic imaging, laboratory and other testing at the doctor's discretion. □ 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.

Date

Date

INFORMED CONSENT

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk 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 chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at

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, method, and or techniques, the doctor.

Chiropractic have been explained to me	to my sati	isfaction	and I h	have conveyed my understanding of both to the
doctor. After careful consideration, I do hereby conse	ent to trea	tment b	y any m	neans, method, and or techniques, the doctor
deems necessary to treat my condition at any time the	nroughout	the enti	re clinic	cal course of my care.
	1	1		Witness Initials
Patient or Authorized person's Signature	Date	•		
REGARDING: X-rays/Imaging Studies				
FEMALES ONLY : please read carefully and check the and have no further questions, otherwise see our recommendation.				
☐ The first day of my last menstrual cycle was on	1	<u>/</u>	Date	
☐ I have been provided a full explanation of when I not pregnant.	am most l	likely to	becom	ne pregnant, and to the best of my knowledge, I am
By my signature below I am acknowledging that the	doctor and	d or a m	ember	of the staff has discussed with me the hazardous

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.

		1	/	Witness Initials
Patient or Authorized person's Signature	Date			