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	Pediatrician/Family MDCity & State					
Last \	/isit: <u>/</u> /Reason for vi	sit:	-			
	is responsible for this bill?					
□ Fa	ther's Social Security #		ner's Social Security #			
	her (please explain):	<u> </u>	, _			
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 doctors for this problem? No Yes,If yes who?					
		·				
5. 6.	How long ago?Days		Month		Years	
	What were the results of past treatment?How is this problem NOW: □ Rapidly Improving □ Improving Slowly □ About the Same □ Gradually Worsening					
7.	ı	apidiy improving 🗆 improvii	ing Slowly - About the s	Same Gradually	vvorsering	
•	□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 a	n injury in an auto accident	?if yes, please	e explain		

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 Poor Posture Hypertension Asthma 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. Parent or Legal Guardian's Signature Date **Doctor Signature** 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 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 **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

Date

Witness Initials

Patient or Authorized person's Signature

necessary in my case.