

**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 \_\_\_\_\_

# Touch of Life

**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 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 Name

Date

\_\_\_\_\_

\_\_\_\_\_

## Activities of Daily Living/Symptoms/Medications

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

HRN: \_\_\_\_\_

### Daily Activities: Effects of Current conditions On Performance

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

Bending	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Concentrating	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Doing computer Work	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Gardening	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Playing Sports	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Recreation Activities	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Shoveling	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sleeping	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Watching TV	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Carrying	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Dancing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Dressing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Lifting	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Pushing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Rolling Over	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sitting	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Standing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Working	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Climbing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Doing Chores	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Driving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Performing Sexual Activity	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Reading	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Running	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sitting to Standing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Walking	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform

# Touch of Life

Please mark P for in the Past, C for Currently have and N for Never

- |   |   |  |  |   |
|---|---|--|--|---|
| <input type="checkbox"/> Headache                           | <input type="checkbox"/> Pregnant (Now)         | <input type="checkbox"/> Dizziness       | <input type="checkbox"/> Prostate Problems     | <input type="checkbox"/> Heartburn            |
| <input type="checkbox"/> Neck Pain                          | <input type="checkbox"/> Frequent Colds/Flu     | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Digestive Problems    | <input type="checkbox"/> Digestive Problems   |
| <input type="checkbox"/> Jaw Pain, TMJ                      | <input type="checkbox"/> Convulsions/Epilepsy   | <input type="checkbox"/> Fainting        | <input type="checkbox"/> Colon Trouble         | <input type="checkbox"/> High Blood Pressure  |
| <input type="checkbox"/> Shoulder Pain                      | <input type="checkbox"/> Tremors                | <input type="checkbox"/> Double Vision   | <input type="checkbox"/> Diarrhea/Constipation | <input type="checkbox"/> Low Blood Pressure   |
| <input type="checkbox"/> Upper Back Pain                    | <input type="checkbox"/> Chest Pain             | <input type="checkbox"/> Blurred Vision  | <input type="checkbox"/> Menopausal Problems   | <input type="checkbox"/> Asthma               |
| <input type="checkbox"/> Mid Back Pain                      | <input type="checkbox"/> Pain w/Cough/Sneeze    | <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Menstrual Problem     | <input type="checkbox"/> Difficulty Breathing |
| <input type="checkbox"/> Low Back Pain                      | <input type="checkbox"/> Foot or Knee Problems  | <input type="checkbox"/> Hearing Loss    | <input type="checkbox"/> PMS                   | <input type="checkbox"/> Lung Problems        |
| <input type="checkbox"/> Hip Pain                           | <input type="checkbox"/> Sinus/Drainage Problem | <input type="checkbox"/> Depression      | <input type="checkbox"/> Bed Wetting           | <input type="checkbox"/> Kidney Trouble       |
| <input type="checkbox"/> Back Curvature                     | <input type="checkbox"/> Swollen/Painful Joints | <input type="checkbox"/> Irritable       | <input type="checkbox"/> Learning Disability   | <input type="checkbox"/> Gall Bladder Trouble |
| <input type="checkbox"/> Scoliosis                          | <input type="checkbox"/> Skin Problems          | <input type="checkbox"/> Mood Changes    | <input type="checkbox"/> Eating Disorder       | <input type="checkbox"/> Liver Trouble        |
| <input type="checkbox"/> Numb/Tingling arms, hands, fingers |   | <input type="checkbox"/> ADD/ADHD        | <input type="checkbox"/> Trouble Sleeping      | <input type="checkbox"/> Hepatitis (A, B, C)  |
| <input type="checkbox"/> Allergies                          |   | <input type="checkbox"/> Ulcers          |  |   |

List Prescription & Non-Prescription drugs you take:

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How did you hear about us?

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**FOR OFFICE USE ONLY**

I have reviewed the above ADL & ROS Form with the above-named patient:

\_\_\_\_\_  
Doctor Signature

\_\_\_\_\_  
Date