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

_____

_____

_____

HAS YOUR CHILD EVER SUFFERED FROM: mark **Y** for YES or **N** for NO

☐ Headaches	☐ Orthopedic Problems.	☐ Digestive Disorders	☐ Behavioral Problems
☐ Dizziness	☐ Neck Problems	☐ Poor Appetite	☐ ADD/ADHD
☐ Fainting	☐ Arm Problems	☐ Stomach Ache	☐ 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 off 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 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	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Concentrating	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Doing computer Work	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Gardening	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Playing Sports	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Recreation Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Shoveling	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sleeping	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Watching TV	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Carrying	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dancing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dressing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Lifting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Pushing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Rolling Over	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Working	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Climbing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Doing Chores	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Performing Sexual Activity	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Reading	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Running	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sitting to Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform

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

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

List Prescription & Non-Prescription drugs you take:

_____

_____

_____

_____

How did you hear about us?

_____

_____

FOR OFFICE USE ONLY

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

_____ _____

Doctor Signature Date