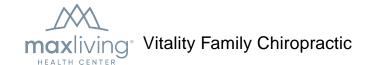


PEDIATRIC HISTORY FORM

PATIENT DEMOGRAPHICS

HR#:					
	ameToday's Date/_/				
	Birth / / Birth Height:Birth Weight:Current Height:				
	Weight: Age: City City				
	ZipPhone (Home) Mother's Name:				
	MobileDOB//				
	name:DOB//				
Pedia	ian/Family MDCity & State				
Last V	t: <u>/</u> Reason for visit:				
Who is	esponsible for this bill?				
□ Fat	r's Social Security # Mother's Social Security #				
□ Oth	(please explain):				
Please	wellness Check-upInjury or AccidentOther xplain: filld is experiencing pain/discomfort please identify where and for how long When did the Problem first begin? Date /UnknownGradualSudden Ever had this problem before? NoYesIf yes when? 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				
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 Dizziness Fainting Seizures/Convulsions Heart Trouble Chronic Earaches Sinus Trouble Scoliosis Bed Wetting Fall in baby walker Fall off bicycle Fall from changing table	Orthopedic Problems Neck Problems Arm Problems Leg Problems Joint Problems Backaches Poor Posture Anemia Colic Fall from bed or couch Fall from high chair Fall off monkey bars	Digestive Disorders Poor Appetite Stomach Ache Reflux Constipation Diarrhea Hypertension Colds/Flu Broken Bones Fall from crib Fall off slide Fall off skateboard/skates	Behavioral Problems ADD/ADHD Ruptures/Hernia Muscle Pain Growing Pains Allergies to Asthma Walking Trouble Sleeping Problems Fall off swing Fall down stairs Other:
I understand that I am directly a	and fully responsible to this office	for all fees associated with chiropra	actic care my child receives.
conveyed my understanding of chiropractic adjustments for the behalf of. I hereby request and	these risks to the doctor. After ca benefit of my minor child for who authorize this office to administer	reful consideration I do hereby req	
			nt of a spouse/former spouse or other ay, I will immediately notify this office.
Parent or Legal Guardian's Sig	nature	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.
Patient or Authorized person's Signature / / Date Witness Initials
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 necessary in my case.