PEDIATRIC HISTORY FORM

PATIENT DEMOGRAPHICS

HR#:				
Childs Nam	eToday's Date_			
Date of Birtl	n/ / Birth Height:Birth Weight:Current	Height:		
Current We	ight: Age: Address	City		
State	ZipPhone (Home)	Mother's Name:		
Mother's Mo	DOB/ /			
Fathers nar	ne:Father's Mobile	DOB <u>///</u>		
Pediatrician	/Family MDCity & State			
Last Visit:	/ / Reason for visit:			
Who is resp	onsible for this bill?			
□ Father's	Social Security # Dother's Social Security #			
□ Other (pl	ease explain):			
	CURRENT PROBLEM:			
Purpose of this visit:Wellness Check-upInjury or AccidentOther				
	ain:			
	is experiencing pain/discomfort please identify where and for how long			
1. WI	nen did the Problem first begin? Date / / /Unknown	GradualSudden		
2. Ev	er had this problem before? NoYesIf yes when?			
3. An	y bowel or bladder problems since this problem began?: (Y/ N) If yes, (Describe):		
4. Ha	ve you seen any other doctors for this problem? No Yes, If yes who?			
	w long ago?Days WeeksMonths	X		
5. Ho		Years		
	nat were the results of past treatment?			
6. WI				
6. Wi 7. Hc	nat were the results of past treatment?			
6. WI 7. Hc	nat were the results of past treatment? w is this problem NOW: □ Rapidly Improving □ Improving Slowly □ About the Sam On & Off	e □ Gradually Worsening		
6. Wi 7. Hc □0 8. Pie	nat were the results of past treatment?	e □ Gradually Worsening		
6. Wi 7. Hc □0 8. Pie	nat were the results of past treatment? w is this problem NOW: □ Rapidly Improving □ Improving Slowly □ About the Sam On & Off ease list any medication taken for this problem:	e □ Gradually Worsening		

¹ ML Form #4

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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 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

2 ML Form #4

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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	Date	

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.

/ / Witness Initials

Patient or Authorized person's Signature

Date

1 ML Form #6

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