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APPLICATION FOR CARE AT PEACOCK FAMILY CHIROPRACTIC

Whom may we thank for connecting you to our office? _____

PEDIATRIC HISTORY FORM

PATIENT DEMOGRAPHICS

Childs Name_____Today's Date____/____/____

Date of Birth____/____/____ 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? _____

HEALTH INFORMATION:

1. Purpose of this visit: _____Wellness Check-up_____Health Concern

   Please explain: _____

   If your child is experiencing pain/discomfort please identify where and for how long _____

2. When did the Problem first begin? Date____/____/_____ _____Unknown _____Gradual _____Sudden
3. Ever had this problem before? No_____Yes_____If yes when? _____
4. Any bowel or bladder problems since this problem began?: (Y / N). If yes, (Describe): _____

   _____
5. Have you seen any other doctors for this problem? No_____ Yes_____ If yes who? _____
6. How long ago?_____Days _____ Weeks _____Months _____Years
7. What were the results of past treatment? _____
8. How is this problem NOW: ☐Rapidly Improving ☐Improving Slowly ☐About the Same

   ☐Gradually Worsening ☐On & Off
9. Please list any supplements your child takes: _____
10. Please list any medications your child takes: _____
11. Has your child ever sustained an injury playing organized sports?_____If yes; please explain

    _____
12. Has your child ever sustained an injury in an auto accident?_____if yes, please explain

    _____

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13. HAS YOUR CHILD EVER SUFFERED FROM: Check those that apply.

☐ 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: _____

INFORMED CONSENT

☐ I understand that I am directly and fully responsible to Peacock Family Chiropractic for all fees associated with chiropractic care my child receives.

☐ Under the terms and conditions of a divorce, separation or other legal authorization, the consent of a spouse/former spouse or other guardian is not required. If my authority select and authorize this care should change in any way, I will immediately notify this office.

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 Peacock Family 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.

The risks associated with exposure to ionization 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.

_____ _____

Parent or Legal Guardian's Signature Date

_____ _____

Doctor Signature Date

JDD,DC 3/2015