MARBLE CITY FAMILY CHIROPRACTIC
Pediatric History Form: AGES 10-17

As a family chiropractic office, we focus on your child's ability to be healthy. Our goals are first to address the issues that brought you to this office, and second, to offer you and your child the opportunity of improved health potential and wellness services.

Whom should we thank for referring you to this office _____

PATIENT DEMOGRAPHICS: **Today's Date: ____/____/_____** **HR# _____**

Child's Full Name: _____ Name she/he go by: _____
Street Address: _____ City: _____
State: _____ Zip: _____ Child's Social Security: _____
Age: _____ Height: _____ Weight: _____ Date of Birth: ____/_____/_____ Sex: _____
Names and Ages of Siblings: _____
Mother/Guardian Name: _____ Mother/Guardian's Mobile Number: _____
Father/Guardian Name: _____ Father/Guardian's Mobile Number: _____
Parent/Guardian E-mail address: _____

Insurance:
Insured's Name: _____ Relationship to Patient: _____
Insured's Date of Birth: _____ Insured's Social Security Number: _____

Child's Current Problems:

Purpose of this visits: ____ 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? 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 the problem NOW: ___ Rapidly Improving ___ Improving Slowly ___ About the same ___ Gradually Worsening ____ On and Off
8. Please list any medication taken for this problem:
_____
9. Does it interfere with your (circle all that apply): Work/School Sleep Daily routine Exercise
10. Is your pain **sharp, dull throbbing, burning, numb** and/or **achy?** _____
11. Is your pain worse in the **morning, evening,** and/or **after specific activity?**
_____
12. Has your child ever sustained an injury playing organized sports? _____ If yes; please explain _____
_____.
13. 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
___ Leg Problems
___ Joint Problems
___ Backaches
___ Hypertension
___ Colds/Flu
___ Broken Bones
___ Fall from bed/couch
___ Fall from high chair
___ Fall skateboard/skates
___ Orthopedic Problems
___ Neck Problems
___ Arm Problems
___ Reflux
___ Constipation
___ Diarrhea
___ Asthma
___ Walking Trouble
___ Sleeping Problems
___ Fall from Crib
___ Fall off slide
___ Digestive Disorders
___ Poor Appetite
___ Stomach Aches
___ Muscle Pain
___ Growing Pains
___ Sinus Trouble
___ Scoliosis
___ Bed Wetting
___ Fall in baby walker
___ Fall off swing
___ Fall off monkey bars
___ Allergies to _____
___ Behavioral Problems
___ ADD/ADHD
___ Ruptures/Hernia
___ Heart Troubles
___ Chronic Earaches
___ Poor Posture
___ Anemia
___ Colic
___ Fall off bicycle
___ Fall down stairs
___ Fall from changing table
Other: _____

Chiropractic History:

Have you ever been to a chiropractor before? Yes No Date of last chiropractic visit: _____
Are other family members under chiropractic care? Yes No Who? _____
The vast majority of our patients have experience dozens of falls of impacts (sports/hobby/work related) that could cause Vertebral Subluxations. Help us discover a few of yours.

- Which of the following sports have you been involved in (circle all that apply)? Football, Basketball, Soccer Running, Gymnastics/Cheerleading, Martial Arts, Other: _____
- Have you ever… Fallen down the stairs, Slipped/Fell on the ground (or ice), Had a sports injury, Broken Bone: If so, which one: _____
- Have you been involved in any car accidents/fender benders? Yes No Date: _____
- Name of Family Doctor/Pediatrician: _____
- Have you ever been seen on an emergency basis? Yes No Reason/Date: _____
- Exercise: None ____ 1-3x week _____ 4-7x week _____ Only PE _____ Sports _____ Other: _____
- Please list any past surgeries (or traumas) and dates: _____
- How many hours of sleep do you get? _____ Do you have trouble falling asleep? _____
- Do you sleep on your stomach? _____

Dietary/Medication History:

- Please list number of doses of antibiotics you have taken:
  - During the past 6 months: _____ During your lifetime: _____
- Please list name and number of doses of any medications (prescription of Over the Counter) taken:
  - During the past 6 months: _____
  - During your lifetime: _____
- Please list all medications you take: _____
- Please list any vitamins/supplements you take: _____
- Vaccination History: _____ Any reaction to them? _____
- Do you consume (check all that apply): Soda ____ White Flour products ____ Fast Foods ____ Friend Foods ____ Sweets ____
- Dairy/Milk products ____ Meat/Fish ____
- Do you have any food allergies (please list them): _____

YOUR BIRTHING PROCESS:

- Location of Birth: Home ____ Birthing Center _____ Hospital (CNM or OB?) _____
- Please list any complication during pregnancy/delivery:
  _____
- Medications during pregnancy/delivery:
  _____
  ____
- Number of ultrasounds during pregnancy: _____
- Birth intervention: Forceps _____ Vacuum _____ Caesarian: planned or emergency:
  _____
- How long we're you breastfed? _____
- We're all developmental milestones met on time? _____

I understand that I am directly and fully responsible to MARBLE CITY FAMILY CHIROPRACTIC for all fees associated with chiropractic care my child receives.

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.

☐ Under the terms and condition 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 the office.

_____ _____

Parent or Legal Guardian's Signature Date

Doctor Signature _____ Date _____