maxliving™

PEDIATRIC HISTORY FORM

Today's Date: ☐☐☐☐

PATIENT DEMOGRAPHICS

Child's Name: _____ Date of Birth: _____ Sex: ○ M ○ F

Birth Height: _____ Birth Weight: _____ Current Height: _____ Current Weight: _____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Mother: _____ Cell: _____

Father: _____ Cell: _____

Who is responsible for this bill? _____

Who referred you to our office? _____

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? ○ Yes ○ No If yes when? _____

3. Any bowel or bladder problems since this problem began? ○ Yes ○ No

(Describe): _____

4. Have you seen any other doctors for this problem? ○ Yes ○ No If yes who? _____

5. How long ago? _____

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 medications or supplements taken for this problem: _____

_____

9. Has your child ever sustained an injury playing organized sports? ○ Yes ○ No

If yes; please explain _____

10. Has your child ever sustained an injury in an auto accident? ○ Yes ○ No

if yes, please explain _____

Discover Chiropractic 1305C N. Bascom Ave, San Jose, Ca 95128 408-985-1111

HAS YOUR CHILD EVER SUFFERED FROM: check applicable items

- ☐ Headaches
- ☐ Dizziness
- ☐ Fainting
- ☐ Seizures/Convulsions
- ☐ Heart Trouble
- ☐ Chronic Earaches
- ☐ Poor Posture
- ☐ Behavioral Problems
- ☐ Fall in baby walker
- ☐ Sleeping Problems
- ☐ Fall from high chair
- ☐ Orthopedic Problems
- ☐ Neck Problems
- ☐ Arm Problems
- ☐ Leg Problems
- ☐ Joint Problems
- ☐ Backaches
- ☐ Hypertension
- ☐ Colds/Flu
- ☐ Fall from bed or couch
- ☐ Broken Bones
- ☐ Fall off slide
- ☐ Digestive Disorders
- ☐ Poor Appetite
- ☐ Stomach Aches
- ☐ Ruptures/Hernia
- ☐ Constipation
- ☐ Diarrhea
- ☐ Asthma
- ☐ Walking Trouble
- ☐ Fall from crib
- ☐ Colic
- ☐ Fall from changing table
- ☐ Anemia
- ☐ ADD/ADHD
- ☐ Reflux
- ☐ Muscle Pain
- ☐ Growing Pains
- ☐ Sinus Trouble
- ☐ Scoliosis
- ☐ Bed Wetting
- ☐ Fall off swing
- ☐ Fall off bicycle
- ☐ Fall off monkey bars
- ☐ Other: _____
- ☐ Allergies to _____

How was the birth?

☐ Forceps or suction ☐ Cord around the neck ☐ Drug Induced ☐ Cesarean Section ☐ Breech

I understand that I am directly and fully responsible to Discover 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 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