

PEDIATRIC HISTORY FORM – MOMENTUM FAMILY CHIROPRACTIC

PATIENT DEMOGRAPHICS

HR#: _____

Today's Date ____/____/____

Childs Name _____

Date of Birth ____/____/____ Age: ____

Birth Height: ____ Birth Weight: ____ Current Height: ____ Current Weight: ____

Address _____

City _____ State ____ Zip _____ Phone (Home) _____

Mother's Name: _____ DOB ____/____/____ Mother's Mobile _____

Father's Name: _____ DOB ____/____/____ Father's Mobile _____

Pediatrician/Family MD _____ City/State _____

Last Visit: ____/____/____ Reason for visit: _____

Who is responsible for this bill? _____

Father's Social Security # ____ - ____ - ____ Mother's Social Security # ____ - ____ - ____

Other (please explain): _____

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**? ____ 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 this problem **NOW?**: Rapidly Improving Improving Slowly About the Same

Gradually Worsening On & Off

8. Please list any **medication taken** for this problem: _____

9. Has your child ever sustained an injury playing organized sports? ___ No ___ Yes If yes; please explain:

10. Has your child ever sustained an injury in an auto accident? ___ No ___ Yes If yes; please explain:

HAS YOUR CHILD EVER SUFFERED FROM: *Check all that apply*

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Orthopedic Problems | <input type="checkbox"/> Digestive Disorders | <input type="checkbox"/> Behavioral Problems |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Neck Problems | <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> ADD/ADHD |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Arm Problems | <input type="checkbox"/> Stomach Aches | <input type="checkbox"/> Ruptures/Hernia |
| <input type="checkbox"/> Seizures/Convulsions | <input type="checkbox"/> Leg Problems | <input type="checkbox"/> Reflux | <input type="checkbox"/> Muscle Pain |
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Joint Problems | <input type="checkbox"/> Constipation | <input type="checkbox"/> Growing Pains |
| <input type="checkbox"/> Chronic Earaches | <input type="checkbox"/> Backaches | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Poor Posture | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Walking Trouble |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Anemia | <input type="checkbox"/> Colds/Flu | <input type="checkbox"/> Sleeping Problems |
| <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Colic | <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Fall off swing |
| <input type="checkbox"/> Fall in baby walker | <input type="checkbox"/> Fall from bed or couch | <input type="checkbox"/> Fall from crib | <input type="checkbox"/> Fall down stairs |
| <input type="checkbox"/> Fall off bicycle | <input type="checkbox"/> Fall from high chair | <input type="checkbox"/> Fall off slide | |
| <input type="checkbox"/> Fall from changing table | <input type="checkbox"/> Fall off monkey bars | <input type="checkbox"/> Fall off skateboard/skates | |

- Allergies to _____
- Other: _____

I understand that I am directly and fully responsible to Momentum 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 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's 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 [Momentum 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.

_____/_____/_____  *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.

MALES/FEMALES: By my signature below, I understand and give consent to be x-rayed if the doctor deems necessary.

_____/_____/_____  *Witness Initials*
Patient or Authorized person's Signature Date

JDD,DC 5/2011