PEDIATRIC HISTORY FORM

PATIENT DEMOGRAPHICS
HR#:_____

Childs Name_____ Today's Date _____/_____/____

Date of Birth _____/_____/_____ Birth Height: _____ Birth Weight: _____ Current Height: _____

Current Weight: _____ Age: _____ Address _____

City _____ State _____ Zip _____ Phone (Home) _____

Mothers 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? _____

☐ 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? _____ If yes; please explain

_____

_____

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

_____

_____

HAS YOUR CHILD EVER SUFFERED FROM: *mark a* **Y for** *YES OR N for No*

☐ Headaches	☐ Orthopedic Problems	☐ Digestive Disorders	☐ Behavioral Problems
☐ Dizziness	☐ Neck Problems	☐ Poor Appetite	☐ ADD/ADHD
☐ Fainting	☐ Arm Problems	☐ Stomach Aches	☐ 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: _____

I understand that I am directly and fully responsible to Greenwood 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 Signature _____ Date_____

JDD,DC 5/2011

maxliving GREENWOOD FAMILY CHIROPRACTIC

Consent to Treat Minor Patient-Without Parent/Legal Guardian Present

By law, any child under the age of 18 years old cannot be seen by a doctor without consent from a parent or legal guardian. If the minor arrives with someone other than a parent or legal guardian, we must have written permission from the parent or legal guardian that this person has been appointed by you to act on your behalf.

Minor's name: _____ **DOB:** _____

For those occasions when you may not be with your child, please list those individuals who may give us consent to see your child:

_____ _____
Name Relationship to Patient

_____ _____
Name Relationship to Patient

LIMITATIONS:
Identify any specific limitations on the kinds of medical services for which this authorization is given. (If none, state "none")

_____

☐ Check here if you wish to give consent for the minor to receive medical care **without an accompanying adult**. This consent shall be in effect for:

- ☐ Date_____ **(only)**
- ☐ Indefinitely, until revoked by written communication

AUTHORIZATION:
I (parent/legal guardian name) _____ request and authorize Greenwood Family Chiropractic and its personnel to deliver routine medical care to my child listed above as may be deemed necessary or advisable in the diagnosis and treatment of the minor child. I am also aware that the adult presenting the child is responsible for payment of the patient portion at the time of service. I have the legal right to preauthorize Greenwood Family Chiropractic and its personnel to deliver routine medical treatment and services to my child. Routine medical care and interventions may include, but are not limited to: medical evaluation, physical exam, chiropractic adjustments, and x-rays. I have read, understand, and give my consent as stipulated above. My signature means that I have read this form and/or have had it read to me and explained in the language that I can understand.

_____
Parent or Legal Guardian (please print) Relationship

_____
Parent or Legal Guardian Signature Date