

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) _____ 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? _____

☐ 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?: (Y / N). 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 **Y** for YES or **N** for NO

- | | | | |
|---|---|---|--|
| <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 Ache | <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"/> Allergies to _____ |
| <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Poor Posture | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Anemia | <input type="checkbox"/> Colds/Flu | <input type="checkbox"/> Walking Trouble |
| <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Colic | <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Sleeping Problems |
| <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 off swing |
| <input type="checkbox"/> Fall off bicycle | <input type="checkbox"/> Fall from high chair | <input type="checkbox"/> Fall off slide | <input type="checkbox"/> Fall down stairs |
| <input type="checkbox"/> Fall from changing table | <input type="checkbox"/> Fall off monkey bars | <input type="checkbox"/> Fall off skateboard/skates | <input type="checkbox"/> Other: _____ |

I understand that I am directly and fully responsible to this office for all fees associated with chiropractic care my child receives.

The risks associated with exposure to x-rays 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. I hereby request and authorize this office to administer healthcare as deemed necessary to my dependent minor child. This authorization also extends to include diagnostic imaging, laboratory and other testing at the doctor's discretion.

☐ 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 Name

Date

Activities of Daily Living/Symptoms/Medications

Patient Name: _____

Date: _____

HRN: _____

Daily Activities: Effects of Current conditions On Performance

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

Bending	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Concentrating	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Doing computer Work	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Gardening	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Playing Sports	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Recreation Activities	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Shoveling	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sleeping	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Watching TV	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Carrying	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Dancing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Dressing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Lifting	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Pushing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Rolling Over	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sitting	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Standing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Working	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Climbing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Doing Chores	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Driving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Performing Sexual Activity	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Reading	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Running	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sitting to Standing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Walking	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform

MaxLiving Fairlawn

Please mark P for in the Past, C for Currently have and N for Never

___ Headache	___ Pregnant (Now)	___ Dizziness	___ Prostate Problems	___ Heartburn
___ Neck Pain	___ Frequent Colds/Flu	___ Loss of Balance	___ Digestive Problems	___ Digestive Problems
___ Jaw Pain, TMJ	___ Convulsions/Epilepsy	___ Fainting	___ Colon Trouble	___ High Blood Pressure
___ Shoulder Pain	___ Tremors	___ Double Vision	___ Diarrhea/Constipation	___ Low Blood Pressure
___ Upper Back Pain	___ Chest Pain	___ Blurred Vision	___ Menopausal Problems	___ Asthma
___ Mid Back Pain	___ Pain w/Cough/Sneeze	___ Ringing in Ears	___ Menstrual Problem	___ Difficulty Breathing
___ Low Back Pain	___ Foot or Knee Problems	___ Hearing Loss	___ PMS	___ Lung Problems
___ Hip Pain	___ Sinus/Drainage Problem	___ Depression	___ Bed Wetting	___ Kidney Trouble
___ Back Curvature	___ Swollen/Painful Joints	___ Irritable	___ Learning Disability	___ Gall Bladder Trouble
___ Scoliosis	___ Skin Problems	___ Mood Changes	___ Eating Disorder	___ Liver Trouble
___ Numb/Tingling arms, hands, fingers		___ ADD/ADHD	___ Trouble Sleeping	___ Hepatitis (A, B, C)
___ Allergies		___ Ulcers		

List Prescription & Non-Prescription drugs you take:

How did you hear about us?

FOR OFFICE USE ONLY

I have reviewed the above ADL & ROS Form with the above-named patient:

Doctor Signature

Date