INSPIRED CHIROPRACTIC

PEDIATRIC HISTORY FORM

PATIENT DEMOGRAPHICS

Child's Name_____ Today's Date _____/_____/____ VRC#: _____

Date of Birth _____/_____/_____ Age: _____ Male ☐ Female ☐ Current Height: _____ Current Weight: _____

Address: _____ City _____ State _____ Zip _____

Phone: (Home) _____ Mother's mobile: _____ Father's mobile: _____

Mother:_____ DOB:_____/_____/_____Father: _____DOB:_____/_____/_____

Pediatrician/Family MD: _____City & State: _____ Last Visit: ____/____/____

Who is responsible for this bill? ☐ Father Social Security # _____-_____-_____ ☐ Mother 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? No Yes *(Describe)*:_____
4. Have you seen any other doctors for this problem? No Yes If yes whom? _____
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 THE FOLLOWING: *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: _____	

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