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Pediatric History Form

It is a pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To help us serve you better, please complete the following information. We look forward to working with you to build better health for your family.

Patient Information:

Patient Name:____Birth Date: _____/_____/_____
Address:________________________________City_______________________State_____Zip:_______
Home Phone:_______________________________Work Phone:_________________________________
Sex: M F Weight:________ Height:_______
Parents Names:______________________________Referred By:______________________________
Name of Insurance Co:__________________________________ Policy #:_______________________
Group #:_________________Name of Insured:__________________Birth Day of Insured: ___/___/___

Purpose for Visit____
Other Doctors seen for this? Y N Drs Names and treatments__________________________________
Other Health Problems? ____
____

Circle any of the following conditions your child has experienced:

Ear Infections	Scoliosis	Seizures	Chronic Colds	Asthma/Allergies
Constipation	ADHD	Bed Wetting	Colic	Growing pains
Temper Tantrums		Car Accident		Other:_________________

Previous Chiropractor:_______________________Date of last visit: ___/___/___ Reason:___________
Name of Pediatrician:_______________________________________Facility:______________________
Date of last visit: ___/___/___ Reason:____

Are you satisfied with the care your child has received there? Y N
Number of doses of Antibiotics your child has taken: During past 6 mo: _____Total During lifetime ___
Any other prescription medications your child has been on:
____
____

Prenatal History:

Complications during pregnancy? Y N List:____
Ultrasounds? Y N Medication during pregnancy/delivery? Y N List:___________________________
Cigarette/Alcohol use during pregnancy? Y N Location of Birth: Hospital Birthing Center Home
Birth Intervention: Forceps Vacuum Extraction C-Section – emergency or planned
Complications during delivery? Y N List:____
Genetic disorders or disabilities? Y N List:____

Feeding History:

Breast Fed: Y N How Long?:_________Formula Fed: Y N How long?:_______Type: _____________
Introduced to solids at: _______months, Cow's milk at ______ months
Food/Juice allergies or intolerances: Y N List:____

Developmental History:

During the following times your child's spine is most vulnerable to stress and should routinely be checked by a doctorof chiropractic for prevention and early detection of spinal nerve interference.
At what age was your child able to:
Hold head up____________Sit up _________Cross crawl ________Stand alone _________Walk alone________

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e, bed, changing table, down stairs, etc.).
Was this the case with your child? Y N

Is/Has your child been involved in any high impact or contact sports? (soccer, football, gymnastics, cheerleading, martial arts, etc) Y N List:____
Has your child ever been in a car accident? Y N List:____
Has your child ever been to the emergency room for any trauma? Y N List:_________________________
Broken any bones? Y N List:____

WE ARE HERE TO SERVE YOU, AND ENCOURAGE YOU TO ASK QUESTIONS.
YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR RESULTS.

Authorization For Care of Minor

I hereby authorize this office and its Doctors to administer care to my Son / Daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Signed: ____Date:______________________
(parent/guardian)

Symptom Survey

List problems from most severe to least severe. Please be as specific as possible.

#1.____

When did you notice the problem?________________What happened?____
Location of pain:____
Progression (circle): same better worse Is the pain constant or does it come and go?________________
Better with (circle): rest ice heat stretching exercise pain relievers topical creams other___________
Worse with (circle): sitting standing walking bending twisting lifting movement other_____________
Quality of pain (circle): sharp shooting dull ache burning stiff stabbing throbbing numb sore
Does your pain radiate (example: travel into arms, legs etc.) Yes No Where?_____________________________________
Severity of pain: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain imaginable) Pain is? Mild Moderate Severe
What time of day is your problem the worse (circle): morning afternoon evening during sleep
What treatment have you received for this condition: medication physical therapy surgery chiropractic other_____

#2.____

When did you notice the problem?________________What happened?____
Location of pain:____
Progression (circle): same better worse Is the pain constant or does it come and go?________________
Better with (circle): rest ice heat stretching exercise pain relievers topical creams other___________
Worse with (circle): sitting standing walking bending twisting lifting movement other_____________
Quality of pain (circle): sharp shooting dull ache burning stiff stabbing throbbing numb sore
Does your pain radiate (example: travel into arms, legs etc.) Yes No Where?_____________________________________
Severity of pain: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain imaginable) Pain is? Mild Moderate Severe
What time of day is your problem the worse (circle): morning afternoon evening during sleep
What treatment have you received for this condition: medication physical therapy surgery chiropractic other_____

#3.____

When did you notice the problem?________________What happened?____
Location of pain:____
Progression (circle): same better worse Is the pain constant or does it come and go?________________
Better with (circle): rest ice heat stretching exercise pain relievers topical creams other___________
Worse with (circle): sitting standing walking bending twisting lifting movement other_____________
Quality of pain (circle): sharp shooting dull ache burning stiff stabbing throbbing numb sore
Does your pain radiate (example: travel into arms, legs etc.) Yes No Where?_____________________________________
Severity of pain: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain imaginable) Pain is? Mild Moderate Severe
What time of day is your problem the worse (circle): morning afternoon evening during sleep
What treatment have you received for this condition: medication physical therapy surgery chiropractic other_____

#4. Additional Complaints (use back of sheet if needed)
____
____

Name:__________________________________Date:____________________Signatuare:___________________________