PEDIATRIC HISTORY FORM

PATIENT DEMOGRAPHICS

Childs Name _____ **HR#** _____

Today's Date _____ **Date of Birth** _____ **Birth Height** _____

Birth Weight _____ **Current Height** _____ **Current Weight** _____

Age _____ **Address** _____

City _____ **Zip** _____

DOB _____ **State** _____ **Phone(home)** _____

Mother's Name _____ **Mother's Mobile Phone** _____ **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

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When did this problem first begin?

Ever had this problem before

☐ Yes ☐ No

If yes, when

Any bowel or bladder problems since this problem began?

☐ Yes ☐ No

If yes, Describe

Have you seen any other doctors for this problem?

☐ Yes ☐ No

If yes who?

How long ago?

☐ Days ☐ Weeks
☐ Months ☐ Years

How many? (Days, weeks, months, years)

What were the results of past treatment?

How is this problem now?

☐ Rapidly improving ☐ Improving Slowly ☐ About the Same
☐ Gradually Worsening ☐ On & Off

Please list any medication taken for this problem

Has your child ever sustained an injury playing organized sports?

☐ Yes ☐ No

If yes, Please explain

Has your child ever sustained an injury in an auto accident?

☐ Yes ☐ No

If yes, Please explain

Has your child ever suffered from:

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

List any Allergies

_____

If other was selected please explain

_____

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.

- [ ] Accept

Signature

Date Signed

_____

Printed Name

_____

Email

_____

Doctor Signature

_____

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
- ☐ No Effect
- ☐ Painful(can do)
- ☐ Painful (limits)
- ☐ Unable to Perform

Doing computer Work
- ☐ No Effect
- ☐ Painful (can do)
- ☐ Painful (limits)
- ☐ Unable to Preform

Concentrating
- ☐ No Effect
- ☐ Painful (can do)
- ☐ Painful (limits)
- ☐ Unable to Perform

Gardening
- ☐ No Effect
- ☐ Painful (can do)
- ☐ Painful (limits)
- ☐ Unable to Perform

Playing Sports
- ☐ No Effect
- ☐ Painful (Can do)
- ☐ Painful (limits)
- ☐ Unable to Perform

Recreation Activities
- ☐ No Effect
- ☐ Painful (can do)
- ☐ Painful (limits)
- ☐ Unable to Perform

Shoveling
- ☐ No Effect
- ☐ Painful (can do)
- ☐ Painful (limits)
- ☐ Unable to Perform

Sleeping
- ☐ No Effect
- ☐ Painful (can do)
- ☐ Painful (limits)
- ☐ Unable to Perform

Watching TV
- ☐ No Effect
- ☐ Painful (can do)
- ☐ Painful (limits)
- ☐ Unable to Perform

Carrying
- ☐ No Effect
- ☐ Painful (can do)
- ☐ Painful (limits)
- ☐ Unable to Perform

Dancing
- ☐ No Effect
- ☐ Painful (can do)
- ☐ Painful (limits)
- ☐ Unable to Perform

Dressing
- ☐ No Effect
- ☐ Painful (can do)
- ☐ Painful (limits)
- ☐ Unable to Perform

Lifting
- ☐ No Effect
- ☐ Painful (can do)
- ☐ Painful (limits)
- ☐ Unable to Perform

Pushing
- ☐ No Effect
- ☐ Painful (can do)
- ☐ Painful (limits)
- ☐ Unable to Perform

Rolling Over
- ☐ No Effect
- ☐ Painful (can do)
- ☐ Painful (limits)
- ☐ Unable to Perform

Sitting
- ☐ No Effect
- ☐ Painful (can do)
- ☐ Painful (limits)
- ☐ Unable to Perform

Standing
- ☐ No Effect
- ☐ Painful (can do)
- ☐ Painful (limits)
- ☐ Unable to Perform

Working
- ☐ No Effect
- ☐ Painful (can do)
- ☐ Painful (limits)
- ☐ Unable to Perform

Climbing
- ☐ No Effect
- ☐ Painful (can do)
- ☐ Painful (limits)
- ☐ Unable to Perform

Doing Chores
- ☐ No Effect
- ☐ Painful (can do)
- ☐ Painful (limits)
- ☐ Unable to Perform

Driving
- ☐ No Effect
- ☐ Painful (can do)
- ☐ Painful (limits)
- ☐ Unable to Perform

Performing Sexual Activity
- ☐ No Effect
- ☐ Painful (can do)
- ☐ Painful (limits)
- ☐ Unable to Perform

Reading

- [ ] No Effect
- [ ] Painful (can do)
- [ ] Painful (limits)
- [ ] Unable to Perform

Running

- [ ] No Effect
- [ ] Painful (can do)
- [ ] Painful (limits)
- [ ] Unable to Perform

Walking

- [ ] No Effect
- [ ] Painful (can do)
- [ ] Painful (limits)
- [ ] Unable to Perform

Sitting to Standing

- [ ] No Effect
- [ ] Painful (can do)
- [ ] Painful (limits)
- [ ] Unable to Perform

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 _____