PEDIATRIC HISTORY FORM

PATIENT DEMOGRAPHICS
Care Card#:_____

Childs Name_____ Today's Date _____/_____/_____

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

Current Height: _____ Current Weight: _____

Address _____

City _____ Province_____ Postal Code _____

Phone (Home) _____

Mothers Name: _____Mother's Mobile _____DOB____/____/____

Fathers name: _____Father's Mobile_____DOB ____/____/____

Pediatrician/Family MD _____City & Province _____

Last Visit: ____/____/____ Reason for visit:_____

Who is responsible for this bill? _____

☐ 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**: _____

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*

☐ Headaches	☐ Orthopedic Problems	☐ Digestive Disorders	☐ Behavioral Problems
☐ Dizziness	☐ Neck Problems	☐ Poor Appetite	☐ ADD/ADHD
☐ Fainting	☐ Arm Problems	☐ Stomach Ache	☐ 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 Holroyd Family Chiropractic for all fees associated with chiropractic care my child receives.

_____ _____

Parent or Legal Guardian's Signature Date

_____ _____

Doctor's Signature Date