PEDIATRIC HISTORY FORM

PATIENT DEMOGRAPHICS

HR#:_______________________

Today's Date _____/_____/____

Childs Name____

Date of Birth _____/_____/______ Age: _____

Current Height: ______ Current Weight: _____

Address ____

City ______________________ State _____ Zip __________ Phone (Home) ______________________

Mother's Name: ________________________ DOB____/____/____ Mother's Mobile _______ ______

Father's Name: ________________________ DOB ____/____/____ Father's Mobile ______________

Pediatrician/Family MD _____________________________________City/State _________________

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

Who is responsible for this bill? ____

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? ____

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? ___ No ___ Yes If yes; please explain: ____
____
____

10. Has your child ever sustained an injury in an auto accident? ___ No ___Yes If yes; please explain:
____
____
____

HAS YOUR CHILD EVER SUFFERED FROM: Circle all that apply

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	Re flux	Muscle Pain
Heart Trouble	Joint Problems	Constipation	Growing Pains
Chronic Earaches	Backaches	Diarrhea	Asthma
Sinus Trouble	Poor Posture	Hypertension	Walking Trouble
Scoliosis	Anemia	Colds/Flu	Sleeping Problems
Bed Wetting	Colic	Broken Bones	Fall off swing
Fall in baby walker	Fall from bed or couch	Fall from crib	Fall downstairs
Fall off bicycle	Fall from highchair	Fall off slide	
Fall from changing table	Fall from monkey bars	Fall off skateboard/skates	

Allergies to____
Other: ____

I understand that I am directly and fully responsible to M.Y. Life Health Center for all fees associated with chiropractic care my child receives. 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.
I certify that the information that I have supplied is correct and accurate to the best of my knowledge. Being the parent or legal guardian of ______________________, I hereby grant permission for my child to receive chiropractic care at M.Y. Life Health center.

____ ___________________
Parent or Legal Guardian's Signature Date

____ ___________________
Doctor's Signature Date