SpineGeek Chiropractic

PEDIATRIC HISTORY FORM

PATIENT DEMOGRAPHICS

HR#:_____

Childs Name_____Today's Date_____/_____/_____

Date of Birth_____/_____/_____ Birth Height:_____Birth Weight:_____Current Height: _____

Current Weight:_____ Age:____ Address _____ City_____

State_____Zip_____Phone (Home) _____ Mother's Name:_____

Mother's Mobile_____DOB __/_____/____

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_____

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?: (Y / N). 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 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

_____

_____

_____

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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 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.

Parent or Legal Guardian's Signature _____ Date _____

Doctor Name _____ Date _____

Dr. Arvay's office communicates office closures, appointment reminders and event notices via text message and email. Please advise which cell phone number and email would be best for these communications. This will enable us to serve you better.

Cell Phone #: _____

Email: _____

Full Name: _____

Birthday: ___/___/_____

Signature: _____ Date: _____

Normal texting/data charges as imposed by your carrier will apply.

JDD, DC 5/2011

FOR OFFICE USE ONLY.

Perfect Patients ☐ Emails ☐ Refersion ☐

Staff Signature _____