Pediatric History Form

PATIENT DEMOGRAPHICS Today's Date:_____

Childs Name_____Date of Birth _____/_____/_____

Age: _____ Birth Height: _____ Birth Weight: _____ 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:_____

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? ___No ___Yes
   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? ___ 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: *Check 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	□ Reflux	□ 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 down stairs
□ Fall off bicycle	□ Fall from high chair	□ Fall off slide	
□ Fall from changing table	□ Fall off monkey bars	□ Fall off skateboard/skates	

□ Allergies to_____

□ Other: _____

INFORMED CONSENT REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I understand that I am directly and fully responsible to Ithaca Family Chiropractic 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.

_____ _____

Parent or Legal Guardian's Signature Date

_____ _____

Doctor's Signature Date

INSURANCE

Do you have Insurance: □Yes □No

I hereby authorize payment to be made directly to ITHACA FAMILY CHIROPRACTIC, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to ITHACA FAMILY CHIROPRACTIC for any and all services I receive at this office.

Name of Insured:_____

Relationship to Patient: _____Birthday of Insured:_____

_____ ____/____/____

Authorized Person's Signature Date

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name _____ Date _____

Please read carefully instructions: Please indicate the number best which best describes the question being asked for each area of complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

○ **Primary concern:**

△ **Secondary concern:**

□ **Third concern:**

☆ **Fourth concern:**

Example:

○	***Primary concern:***	*Headaches*
△	***Secondary concern:***	*Neck*
□	***Third concern:***	*Low Back*
☆	***Fourth concern:***	*Shoulder*

No Pain ***Worst Possible Pain***

☆0 *1* *2* □*3* *4* △*5* *6* *7* ○*8* *9* *10*

1 – What is your pain RIGHT NOW?

No Pain _____ **Worst Possible Pain**

0 1 2 3 4 5 6 7 8 9 10

2 – What is your TYPICAL or AVERAGE pain?

No Pain _____ **Worst Possible Pain**

0 1 2 3 4 5 6 7 8 9 10

3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

No Pain _____ **Worst Possible Pain**

0 1 2 3 4 5 6 7 8 9 10

4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No Pain _____ **Worst Possible Pain**

0 1 2 3 4 5 6 7 8 9 10

OTHER COMMENTS: _____