AUTHORITY
CHIROPRACTIC

Pediatric History Form

Child's Name _____ Date of Birth_____/_____/_____ Age_____

Birth Height/Weight _____ Current Height/Weight _____

Address _____City_____State_____ Zip _____

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?_____

Father's Social Security # _____ Mother's Social Security #_____

PURPOSE OF THIS VISIT (Circle) Wellness Check-Up Injury or Accident Other

Please explain: _____

_____

When did the problem first begin? _____ *(Or Circle)* Unknown Gradual Sudden

Have you seen any other doctors for this problem? (*Circle*) YES NO

Please describe recommendations/treatment/results: _____

_____

_____

How is this problem **NOW**? (*Circle*) Improving Worsening Same

If your child is experiencing pain/discomfort, please identify where and for how long:

_____

_____

Please list any medications your child takes and for what reason: _____

_____

_____

Has your child ever sustained an injury playing organized sports? (Circle) Yes No

Has your child ever sustained an injury in an auto accident? (Circle) Yes No

Was your child born before 40 weeks gestation? If yes, please explain _____

(Please circle) Vaginal Delivery OR Cesarean/C-section

Did your child sustain any trauma during labor/delivery? 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	☐ Colic	☐ Growing Pains
☐ Chronic Earaches	☐ Backaches	☐ Latching/Feeding Difficulty	☐ Asthma
☐ Sinus Trouble	☐ Poor Posture	☐ Diarrhea	☐ Hypertension
☐ Scoliosis	☐ Anemia	☐ Constipation	☐ Sleeping Problems
☐ Bed Wetting	☐ Broken Bones	☐ Colds/Flu	☐ Walking Trouble
☐ Fall from bed or couch	☐ Fall from crib	☐ Fall down stairs	☐ Fall in baby walker
☐ Fall from high chair	☐ Fall from changing table	☐ Fall off slide/playground	☐ Fall off bicycle

☐ Other: _____

Please list any allergies: _____

Notes: _____

PAIN SCALE *(Please complete for your child **if applicable**. For reference, 0 = no pain and 10 = worst possible pain.)*

1. How would you rate your pain right now?

0 1 2 3 4 5 6 7 8 9 10

2. What is your typical or AVERAGE 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?)

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?)

0 1 2 3 4 5 6 7 8 9 10

I understand that I am directly and fully responsible to Authority 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