Whom may we thank for referring you to our office? _____

BUCHAR FAMILY CHIROPRACTIC

PEDIATRIC HISTORY FORM

3015 E. New York St. Ste. A11 Aurora, IL 60504
bucharfamilychiro.com 630-820-1330

Today's Date _____/_____/_____

Name_____ Date of Birth _____/_____/_____ Social Security # _____-_____-_____

Address _____ City _____ State _____ Zip _____

Phone (Home) _____ Mothers mobile: _____Fathers mobile: _____

Mother_____ DOB_____/_____/_____Father _____DOB_____/_____/_____

Pediatrician/Family MD _____City & State _____ Last Visit: ____/____/____

Purpose of last visit _____

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

Ever been under chiropractic care? ☐ No ☐ Yes: Who/When? _____

Who is responsible for this bill? ☐ Mother ☐ Father ☐ Other (please explain) _____

Insurance Company _____

CHILD'S CURRENT PROBLEM:

Purpose of this visit: _____Wellness Check-up _____Injury or Accident _____Other

If 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:** (circle) Rapidly Improving Improving Slowly About the Same

Gradually Worsening On & Off

8. Please list any **medication taken** for this problem:

_____

HAS YOUR CHILD EVER SUFFERED FROM:

□ 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	□ Allergies to_____
□ Sinus Trouble	□ Poor Posture	□ Hypertension	□ Allergies to_____
□ Asthma	□ Scoliosis	□ Anemia	□ Allergies to_____
□ Colds/Flu	□ Walking Trouble	□ Bed Wetting	□ Other: _____
□ Colic	□ Broken Bones	□ Sleeping Problems	□ Other: _____

HAS YOUR CHILD EVER SUFFERED THE FOLLOWING SPINAL TRAUMAS:

□ Fall in baby walker	□ Fall from bed or couch	□ Fall off skateboard or skates
□ 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	□ Other: _____

Has your child ever sustained an injury playing organized sports? _____ If yes; please explain_____
_____

Has your child ever sustained an injury in an auto accident? _____ if yes; please explain_____
_____

PREGNANCY HISTORY:
Third Trimester Presentation: _____Vertex _____Breech _____Transverse _____Face/Brow

Type of Birth: _____Normal Vaginal _____Forceps _____Cesarean _____Suction Cap or Vacuum

Location: _____Home _____Hospital _____Birthing Center _____Other: _____

Problems during Pregnancy:_____

Problems during Labor/Delivery: _____

Was there presence of: _____Jaundice? (Yellow) _____Cyanosis? (Blue) _____Congenital Anomalies/Defects?

If yes, please explain_____

INFANT HISTORY:
Infant feeding: _____Breast _____Bottle If Bottle; which Formula? _____

Number of Hours sleep per night _____ **Quality of Sleep:** _____Good _____Fair _____Poor

List all **IMMUNIZATIONS** you child has had**:** _____
_____

Has your child ever been treated at the emergency room? _____ If yes; please explain _____

Has your child ever been hospitalized? _____ If yes; please explain _____

Has your child ever had any Surgeries? _____ If yes; please explain _____

Is your child currently on any medication? _____ If yes; please list: _____

DID THE CHILD EVER SHOW A DELAY FOR ANY OF THE FOLLOWING:

Respond to sound_____ Follow an object with his/her eyes_____ Hold heel up_____

Sit Alone_____ Crawl_____ Stand_____ Walk alone_____

INFORMED CONSENT

I understand that I am directly and fully responsible to Buchar 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