Palmer CHIROPRACTIC
a family wellness clinic

PEDIATRIC HISTORY FORM **FOR CHILDREN AGES 6-17 YEARS OLD**

Today's Date ___/___/___ How did you hear about our office? _____

Child's Name _____
Date of Birth: ___/___/___ Age: ____ Height: _____ Weight: _____
Address: _____
City: _____ State: _____ Zip: _____
Mother's Name: _____ Mother's Mobile: _____
Father's Name: _____ Father's Mobile: _____
Family e-mail: _____
(our office uses e-mail to inform you of closures, changes in hours due to weather, vacation, etc)
Pediatrician/Family MD: _____
City/State: _____ Last visit: ___/___/___
Reason for last visit: _____
I authorize contact in the following manner: (check all that apply) ▢ text/email ▢ cell
▢ leave message with detailed information ▢ leave message with call back number only

Reason for contacting our office:
Please identify the condition(s) prompting this visit: _____
_____
If your child is experiencing Pain/Discomfort please identify where and for how long: _____
_____
When did the problem first begin? Date: ___/___/___ ▢ unknown ▢ gradual ▢ sudden
Has he/she ever had this problem before? ▢ No ▢ Yes If yes, when? _____
_____
Have you seen any other doctors for this problem? ▢ No ▢ Yes If yes, who and what care was delivered? _____
_____
Please list any medication taken for this concern? _____
How is this problem NOW? ▢ Rapidly improving ▢ Improving Slowly ▢ About the same
▢ Gradually worsening ▢ On & Off
Has your child ever sustained an injury playing organized sports? ▢ No ▢ Yes If yes, please explain _____
_____
Has your child ever been involved in a motor vehicle accident? ▢ No ▢ Yes If yes, please explain _____
_____

Please underline any of the following experienced in the past, circle any currently experiencing:

Allergies	Cold/Flu	Heart trouble	Poor appetite
Anemia	Constipation	Hyperactivity	Behavioral Problems
Chronic earaches	Diarrhea	Hypertension	Ruptures/Hernias
Asthma	Seizures	Joint pain	Sinus trouble
Backache	Diabetes	Arm Pain	Sleep Problems
Bed Wetting	Dizziness	Leg Pain	Walking Problems
Headaches	Fainting	Neck Pain	Digestion Problems
Scoliosis	Poor Posture	Muscle Pain	Weight Problems

▢ Allergies: _____
▢ Medications: _____
▢ Congenital abnormalities: _____
▢ Surgeries, broken bones: _____

Has your child been treated for an emergency? ▢ No ▢ Yes If yes, please describe: _____
_____

Has your child been prescribed antibiotics in the last 6 months? ▢ No ▢ Yes
Any other information, not mentioned above, that you would like the doctor to know about?
_____
_____

I certify that I am the legal guardian of the patient listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information. I authorize this office and its staff to examine and treat the patient's condition as the doctors see fit. I hereby authorize the doctors to release all necessary information to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred. I grant the use of my signed statement of authorization with my signature for any required insurance submissions. I understand and agree that all services rendered will be charged to me and I am responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of care and treatment.

_____ Date _____
Parent or Legal Guardian's Signature

_____
Printed Name of Parent or Legal Guardian