PEDIATRIC HISTORY FORM

PATIENT DEMOGRAPHICS **ID#**:______________________

Childs Name____ Age: _____ Today's Date _____/_____/_____

Date of Birth _____/_____/_____ **Birth** - Height: _______ Weight: _______ **Current** - Height: _______ Weight: _______

Address ____

City ______________________________ State _______ Zip ___________________ Phone (Home) _____________________

Mother: ____ Mother's Cell _________________________ DOB____/____/____

Father: ____ Father's Cell __________________________ DOB ____/____/____

Pediatrician/Family MD ____City & State _________________________________

Last Visit: ____/____/____ Reason for visit:____

Who is responsible for this bill? ____

☐ Other *(please explain):* ____

CHILD'S CURRENT PROBLEM:

Purpose of this visit: Wellness Check-up ______ Injury ______ 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: ______________________________

   ____
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: ____

Name: ____ DOB: ___/___/___ID: ____________

9. Has your child ever sustained an injury playing organized sports? No_______ Yes_______ If yes: ________________________________

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Child's Name: ____ DOB: __________________________ ID#: _______________________

10. Has your child ever sustained an injury in an auto accident? No_______ Yes_______ If yes: ____________________________________

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HAS YOUR CHILD EVER SUFFERED FROM: *mark* **Y** for *YES or* **N** for *NO*

☐ Headaches	☐ Seizures/Convulsions	☐ Poor Posture	☐ Fall in baby walker
☐ Orthopedic Problems	☐ Leg Problems	☐ Hypertension	☐ Fall from bed or couch
☐ Digestive Disorders	☐ Reflux	☐ Asthma	☐ Fall from crib
☐ Behavioral Problems	☐ Muscle Pain	☐ Scoliosis	☐ Fall off swing
☐ Dizziness	☐ Heart Trouble	☐ Anemia	☐ Fall off bicycle
☐ Neck Problems	☐ Joint Problems	☐ Colds/Flu	☐ Fall from high chair
☐ Poor Appetite	☐ Constipation	☐ Walking Trouble	☐ Fall off slide
☐ ADD/ADHD	☐ Growing Pains	☐ Bed Wetting	☐ Fall down stairs
☐ Fainting	☐ Chronic Earaches	☐ Colic	☐ Fall off changing table
☐ Arm Problems	☐ Backaches	☐ Broken Bones	☐ Fall off monkey bars
☐ Stomach Ache	☐ Diarrhea	☐ Sleeping Problems	☐ Other: ______________
☐ Ruptures/Hernia	☐ Allergies to___________	☐ Sinus Trouble	______________________

I understand that I am directly and fully responsible to Beaverton Family Chiropractic, PC for all fees associated with chiropractic care my child receives.

The risks associated with 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.

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. _______ (Initial)

____ ______________________

Parent or Legal Guardian's Signature Date

Doctor's Notes: ____

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