

PEDIATRIC HISTORY FORM

PATIENT DEMOGRAPHICS

HR#: _____

Child's Name _____ Today's Date ____ / ____ / ____

Date of Birth ____ / ____ / ____ Birth Height: _____ Birth Weight: _____ Current Height: _____

Current Weight: _____ Age: _____ Address _____ City _____

State _____ Zip _____ Phone (Home) _____ Mother's Name: _____

Mother's Mobile _____ DOB ____ / ____ / ____

Father's name: _____ Father's Mobile _____ DOB ____ / ____ / ____

Pediatrician/Family MD _____ City & State _____

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

Who is responsible for this bill? _____

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

☐ Other (please explain): _____

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?: (Y / N). 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? _____ If yes, please explain _____
10. Has your child ever sustained an injury in an auto accident? _____ if yes, please explain _____

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

- | | | | |
|---|---|---|--|
| ☐ Headaches | ☐ Orthopedic Problems. | ☐ Digestive Disorders | ☐ Behavioral Problems |
| ☐ Dizziness | ☐ Neck Problems | ☐ Poor Appetite | ☐ ADD/ADHD |
| ☐ Fainting | ☐ Arm Problems | ☐ Stomach Ache | ☐ 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 | ☐ Asthma |
| ☐ Scoliosis | ☐ Anemia | ☐ Colds/Flu | ☐ Walking Trouble |
| ☐ Bed Wetting | ☐ Colic | ☐ Broken Bones | ☐ Sleeping Problems |
| ☐ Fall in baby walker | ☐ Fall from bed or couch | ☐ 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 | ☐ Fall off skateboard/skates | ☐ Other: _____ |

I understand that I am directly and fully responsible to this office for all fees associated with chiropractic care my child receives.

The risks associated with exposure to 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. I hereby request and authorize this office to administer healthcare as deemed necessary to my dependent minor child. This authorization also extends to include diagnostic imaging, laboratory and other testing at the doctor's discretion.

☐ 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 Name

Date

Activities of Daily Living/Symptoms/Medications

Patient Name: _____

Date: _____

HRN: _____

Daily Activities: Effects of Current conditions On Performance

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

Bending	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Concentrating	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Doing computer Work	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Gardening	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Playing Sports	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Recreation Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Shoveling	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sleeping	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Watching TV	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Carrying	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dancing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dressing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Lifting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Pushing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Rolling Over	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Working	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Climbing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Doing Chores	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Performing Sexual Activity	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Reading	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Running	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sitting to Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform

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Please mark P for in the Past, C for Currently have and N for Never

☐ Headache	☐ Pregnant (Now)	☐ Dizziness	☐ Prostate Problems	☐ Heartburn
☐ Neck Pain	☐ Frequent Colds/Flu	☐ Loss of Balance	☐ Digestive Problems	☐ Digestive Problems
☐ Jaw Pain, TMJ	☐ Convulsions/Epilepsy	☐ Fainting	☐ Colon Trouble	☐ High Blood Pressure
☐ Shoulder Pain	☐ Tremors	☐ Double Vision	☐ Diarrhea/Constipation	☐ Low Blood Pressure
☐ Upper Back Pain	☐ Chest Pain	☐ Blurred Vision	☐ Menopausal Problems	☐ Asthma
☐ Mid Back Pain	☐ Pain w/Cough/Sneeze	☐ Ringing in Ears	☐ Menstrual Problem	☐ Difficulty Breathing
☐ Low Back Pain	☐ Foot or Knee Problems	☐ Hearing Loss	☐ PMS	☐ Lung Problems
☐ Hip Pain	☐ Sinus/Drainage Problem	☐ Depression	☐ Bed Wetting	☐ Kidney Trouble
☐ Back Curvature	☐ Swollen/Painful Joints	☐ Irritable	☐ Learning Disability	☐ Gall Bladder Trouble
☐ Scoliosis	☐ Skin Problems	☐ Mood Changes	☐ Eating Disorder	☐ Liver Trouble
☐ Numb/Tingling arms, hands, fingers		☐ ADD/ADHD	☐ Trouble Sleeping	☐ Hepatitis (A, B, C)
☐ Allergies		☐ Ulcers		

List Prescription & Non-Prescription drugs you take:

How did you hear about us?

FOR OFFICE USE ONLY

I have reviewed the above ADL & ROS Form with the above-named patient:

Doctor Signature

Date