PEDIATRIC HISTORY FORM

PATIENT DEMOGRAPHICS HR#:_____

Childs Name_____ Today's Date _____/_____/____

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

Current Weight: _____ Age: _____ Address _____

City _____ State _____ Zip _____ Phone (Home) _____

Mothers Name: _____Mother's Mobile _____DOB____/____/____

Fathers 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 HEALTH CONCERN:

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. Has your child ever had this problem before? No_____ Yes_____ If yes, when? _____
3. Any bowel or bladder problems since this problem began? If yes, please explain:
4. Have you seen any other doctors for this problem? No_____ Yes_____
   If yes, who? _____
5. How long ago? Date ____/____/_____ Or please estimate: _____ ago.
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 **medication/s** taken for this problem:
9. Has your child ever sustained an injury playing organized sports? No_____ Yes_____ If yes, please explain:
10. Has your child ever sustained an injury in an auto accident? No_____ Yes_____ 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	☐ Constipation	☐ Growing Pains
☐ Chronic Earaches to_____	☐ Backaches	☐ Diarrhea	☐ Allergies
☐ Sinus Trouble	☐ Poor Posture	☐ Hypertension	☐ Asthma
☐ Scoliosis	☐ Anemia	☐ Colds/Flu	☐ Walking Trouble
☐ Bed Wetting	☐ Broken Bones	☐ Sleeping Problems	☐ Fall off swing
☐ Fall in baby walker	☐ Fall from bed or couch	☐ Fall from crib	☐ Fall down stairs
☐ Fall off bicycle	☐ Fall from high chair	☐ Fall off slide	☐ Colic
☐ Fall from changing table	☐ Fall off monkey bars	☐ Fall off skateboard/skates	
	☐Other:_____		

I understand that I am directly and fully responsible to Superior Healthcare for all fees associated with the 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 Signature _____ Date_____

7/2015