

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 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?: 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

HAS YOUR CHILD EVER SUFFERED FROM: mark a **Y** for **YES** OR **N**

- 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 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 West Cobb 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 Signature _____ Date _____
JDD,DC 5/2011