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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:____

CHILD'S CURRENT PROBLEM:

Purpose of this visit: □ Wellness check-up □ Accident or Injury □ Other: _________________

*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**? □ Yes □ No If yes when? ________________________________
3. Any **bowel or bladder** problems since this problem began?: □ Yes □ No f yes, please describe: ____
4. Have you seen any **other doctors** for this problem? □ Yes □ No 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? □ Yes □ No If yes, please explain:
10. Has your child ever sustained an injury in an auto accident? □ Yes □ No If yes, please explain

HAS YOUR CHILD EVER SUFFERED FROM: *mark a* **Y for** *YES OR N No*

□ 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 ___________________
□ 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: ___________________

Pregnancy:

□ Yes □ No Were there any complications to pregnancy? ____________________________________

□ Yes □ No Was mom on any medications, prescription or over the counter? ___________________

□ Yes □ No Did mom or dad smoke during pregnancy?

□ Yes □ No Was the baby ever in the Breech position?

How many ultrasounds were performed? ____________________

Birth and Delivery:

Where was the baby born? □ Home □ Hospital □ Birthing Center □ Other: ____________________

Was the delivery: □ Vaginal □ C-section Were there any devices used? □ forceps □ vacuum

Was oxytocin/Pitocin used? □ Yes □ No Was an epidural used? □ Yes □ No

How long was the labor? ___________________ How long was the delivery? _______________________

Infancy:

□ Yes □ No Was the infant vaccinated?

□ Yes □ No Was there any prolonged use of medications or an inhaler? If yes, which?

____

□ Yes □ No Did the infant suffer any traumas such as serious falls or car accidents?

□ Yes □ No Has the infant been under regular chiropractic care?

Childhood Years:

□ Yes □ No Did the child have any childhood illnesses (listed above).

□ Yes □ No Does the child play youth sports?

□ Yes □ No Has the child fallen from a height over 3ft?

□ Yes □ No Was the Child involved in any car accidents?

□ Yes □ No Has there been any prolonged use of meds? ____________________________________

□ Yes □ No Has the child suffered any emotional traumas? ____________________________________

□ Yes □ No Is there any other pertinent health information that you feel would be helpful?

I understand that I am directly and fully responsible to Ithaca 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______________