

# 307 CHIROPRACTIC HEALTH CENTER PEDIATRIC HISTORY FORM

## PATIENT DEMOGRAPHICS

HR#: \_\_\_\_\_

Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Child's Name \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_

Birth Height: \_\_\_\_ Birth Weight: \_\_\_\_ Current Height: \_\_\_\_ Current Weight: \_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_ Phone (Home) \_\_\_\_\_

Mother's Name: \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Mother's Mobile \_\_\_\_\_

Father's Name: \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Father's Mobile \_\_\_\_\_

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? \_\_\_ 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*

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Headaches                | <input type="checkbox"/> Orthopedic Problems    | <input type="checkbox"/> Digestive Disorders        | <input type="checkbox"/> Behavioral Problems |
| <input type="checkbox"/> Dizziness                | <input type="checkbox"/> Neck Problems          | <input type="checkbox"/> Poor Appetite              | <input type="checkbox"/> ADD/ADHD            |
| <input type="checkbox"/> Fainting                 | <input type="checkbox"/> Arm Problems           | <input type="checkbox"/> Stomach Aches              | <input type="checkbox"/> Ruptures/Hernia     |
| <input type="checkbox"/> Seizures/Convulsions     | <input type="checkbox"/> Leg Problems           | <input type="checkbox"/> Reflux                     | <input type="checkbox"/> Muscle Pain         |
| <input type="checkbox"/> Heart Trouble            | <input type="checkbox"/> Joint Problems         | <input type="checkbox"/> Constipation               | <input type="checkbox"/> Growing Pains       |
| <input type="checkbox"/> Chronic Earaches         | <input type="checkbox"/> Backaches              | <input type="checkbox"/> Diarrhea                   | <input type="checkbox"/> Asthma              |
| <input type="checkbox"/> Sinus Trouble            | <input type="checkbox"/> Poor Posture           | <input type="checkbox"/> Hypertension               | <input type="checkbox"/> Walking Trouble     |
| <input type="checkbox"/> Scoliosis                | <input type="checkbox"/> Anemia                 | <input type="checkbox"/> Colds/Flu                  | <input type="checkbox"/> Sleeping Problems   |
| <input type="checkbox"/> Bed Wetting              | <input type="checkbox"/> Colic                  | <input type="checkbox"/> Broken Bones               | <input type="checkbox"/> Fall off swing      |
| <input type="checkbox"/> Fall in baby walker      | <input type="checkbox"/> Fall from bed or couch | <input type="checkbox"/> Fall from crib             | <input type="checkbox"/> Fall down stairs    |
| <input type="checkbox"/> Fall off bicycle         | <input type="checkbox"/> Fall from high chair   | <input type="checkbox"/> Fall off slide             |  |
| <input type="checkbox"/> Fall from changing table | <input type="checkbox"/> Fall off monkey bars   | <input type="checkbox"/> Fall off skateboard/skates |  |

- Allergies to \_\_\_\_\_
- Other: \_\_\_\_\_

I understand that I am directly and fully responsible to 307 Chiropractic Health Center 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's Signature

\_\_\_\_\_  
Date

# Informed Consent

**REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:**

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at 307 Chiropractic Health Center have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.


\_\_\_\_\_ /\_\_\_\_\_/\_\_\_\_\_  Witness Initials  
 Patient or Authorized Person’s Signature                      Date

**REGARDING: X-rays/Imaging Studies**

**FEMALES ONLY →** please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.

- The first day of my last menstrual cycle was on \_\_\_\_-\_\_\_\_-\_\_\_\_ (Date)
- I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

\_\_\_\_\_ /\_\_\_\_\_/\_\_\_\_\_  Witness Initials  
 Patient or Authorized Person’s Signature                      Date