PEDIATRIC HISTORY FORM

You were born to be healthy all of your life. Good health depends upon everything in your body being connected to your brain by nerves that pass between the bones of your spine. A subluxation is a disconnection between your brain and body affecting your health. Chiropractic restores this connection.

PATIENT DEMOGRAPHICS

Childs Name:_____ Age: _____ Today's Date: ____/____/____

DOB: _____/_____/_____ At birth: Height: _____ Weight: _____ Weeks gestation: _____ Labor hrs: _____

Gender: ☐ M ☐ F Phone (Home) _____ Current Height: _____ Current Weight: _____

Address: _____City: _____ State: _____ Zip: _____

Email Address: _____ Referred By: _____

Mother's Name: _____ DOB: ____/____/____ Mother's Mobile: _____

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

Pediatrician/Family MD _____ Last Visit: ____/____/____

Reason for visit: _____ Any previous chiropractic care? ☐ Yes ☐ No

Who is responsible for this bill? _____ Vaccinations: ☐ Yes ☐ No ☐ Delayed

Please list any medications: _____

CHILD'S CURRENT COMPLAINT:

Reason for seeking care: _____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 and when?

_____

5. What were the results of past treatment? _____

6. How is this problem NOW? ☐ Rapidly Improving ☐ Improving Slowly ☐ About the Same

☐ Gradually Worsening ☐ On & Off

7. Please list any medication taken for this problem: _____

8. Has your child ever sustained an injury playing organized sports? ___ No ___ Yes If yes; please explain:

_____

_____

9. Has your child ever sustained an injury in an auto accident? ___ No ___ Yes If yes; please explain:

_____

10. Location of birth: ☐ Hospital ☐ Birthing Center ☐ Home OBGYN/Midwife: _____

11. Birth: ☐ Vaginal w/epidural ☐ Natural w/o epidural ☐ C-section Were forceps or vacuum used?_____

12. How long was labor process? _____ Feeding: ☐ Breast feed or ☐ Formula

13. How was the pregnancy? (Complications, Ultrasounds, etc.) Please explain: _____

_____

14. How was the child's birth process? 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	☐ Backaches	☐ Diarrhea	☐ Asthma
☐ Sinus Trouble	☐ Poor Posture	☐ Hypertension	☐ Walking Trouble
☐ Scoliosis	☐ Anemia	☐ Colds/Flu	☐ Sleeping Problems
☐ Bed Wetting	☐ Colic	☐ Broken Bones	☐ 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	
☐ Fall from changing table	☐ Fall off monkey bars	☐ Fall off skateboard/skates	

☐ Allergies to_____

☐ Other: _____

I understand that I am directly and fully responsible to Limitless 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