Maximized Life Chiropractic

Pediatric History Form

PATIENT DEMONGRAPHICS

Childs Name____ Today's Date ____/____/___

HR#:__________________

Date of Birth ____/____/_____ Birth Height: ______ Birth Weight: ______ Current Height: _____ Current Weight: ____ Age: ____

Address ____ City __________________ State ______ Zip ________________

Phone (Home) _____________________ Mothers mobile: _____________________ Fathers mobile: _______________________

Mother__________________________ DOB____/____/_______Father ________________________DOB____/____/______

Pediatrician/Family MD _________________________________City & State ________________________ Last Visit: ___/___/___

Who is responsible for this bill? ☐ Father Social Security # _____-_____-______ ☐ Mother 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?: No 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____ ____

*please turn over and complete back page

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