PEDIATRIC HISTORY FORM

PATIENT DEMOGRAPHICS HR#:_____

Today's Date _____/_____/____

Childs Name_____

Date of Birth _____/_____/_____ Age: _____

Address _____City _____ State _____ Zip _____

Phone(Home)_____Email_____

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:

What brought you into the office today? _____Wellness Check-up _____Injury or Accident _____Other

_____

*Is your child experiencing **Pain/Discomfort?*** **_____**Yes _____No

1. **Where?_____**
2. **When** did the Problem first begin? Date ___/___/___ __Unknown __Gradual __Sudden
3. **Ever had** this problem **before**? ___ No ___Yes If yes, when? _____
4. Any **bowel or bladder** problems since this problem began?: If yes, describe:

   _____
5. Have you seen any **other doctors** for this problem? ___No ___Yes If yes, who?

   _____
6. How long ago? _____Days _____Weeks _____Months _____Years
7. Please list any **medication taken** for this problem: _____

_____

8. What were the results of past treatment? _____
9. Is this problem? □ Rapidly Improving □ Improving Slowly □ About the Same □ Gradually Worsening □ On & Off

PREGNANCY INFORMATION:

How was your pregnancy?_____

Any pregnancy complications?_____

Did you take any medication during your pregnancy?_____

Other information_____

DELIVERY INFORMATION:

Location of birth: (circle one) Hospital Birth Center Home

Birth Intervention: (Circle one) Forceps Vacuum Extraction Caesarean Section

Induced? Yes/No Explain:_____

Medications during delivery:_____

Other Information:_____

POST BIRTH INFORMATION:

Birth Weight:_____ Birth Length:_____

Breast Fed: Yes/No How long?_____ Formula Fed: Yes/No How Long?_____

Introduced solid foods at _____ Months

Food allergies or intolerances:_____

Past antibiotics/prescriptions?_____

Present antibiotics/prescriptions?_____

Over the counter medications (Tylenol, cough syrup, laxatives, etc)_____

_____

List all surgical operations and years_____

_____

Has your child ever been knocked unconscious? Yes / No Fractured a bone? Yes / No

If yes, please explain:_____

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*

□ 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	□ Sports Injury
□ Fall from changing table	□ Fall off monkey bars	□ Fall off skateboard/skates	

□ Allergies to_____

□ Other: _____

ACTIVITIES OF DAILY LIVING

ACTIVITY:	EFFECT:			
Holding head up	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Tummy Time	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Nursing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sitting Up	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Crawling	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Standing Alone	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Walking Alone	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Other:_____	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Other:_____	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform

CONSENT

I understand that I am directly and fully responsible to Cornerstone 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, if recommended, 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