

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

Was He/She born Natural or Cesarean? \_\_\_\_\_

### PURPOSE FOR TODAY'S VISIT::

\_\_\_\_\_ Wellness Check-up \_\_\_\_\_ Injury or Accident \_\_\_\_\_ Other

Please explain: \_\_\_\_\_

If your child is experiencing **Any issues 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? \_\_\_\_\_ If yes; please explain

\_\_\_\_\_

\_\_\_\_\_

10. Has your child ever sustained an injury in an auto accident? \_\_\_\_\_ if yes, please explain

\_\_\_\_\_

\_\_\_\_\_

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

- |   |   |   |  |
|---|---|---|--|
| <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"/> Allergies to _____  |
| <input type="checkbox"/> Sinus Trouble            | <input type="checkbox"/> Poor Posture           | <input type="checkbox"/> Hypertension               | <input type="checkbox"/> Asthma              |
| <input type="checkbox"/> Scoliosis                | <input type="checkbox"/> Anemia                 | <input type="checkbox"/> Colds/Flu                  | <input type="checkbox"/> Walking Trouble     |
| <input type="checkbox"/> Bed Wetting              | <input type="checkbox"/> Colic                  | <input type="checkbox"/> Broken Bones               | <input type="checkbox"/> Sleeping Problems   |
| <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 off swing      |
| <input type="checkbox"/> Fall off bicycle         | <input type="checkbox"/> Fall from high chair   | <input type="checkbox"/> Fall off slide             | <input type="checkbox"/> Fall down stairs    |
| <input type="checkbox"/> Fall from changing table | <input type="checkbox"/> Fall off monkey bars   | <input type="checkbox"/> Fall off skateboard/skates | <input type="checkbox"/> Other: _____        |

I understand that I am directly and fully responsible to *Maximized Living North Dallas* 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