

## CHERRY CITY CHIROPRACTIC 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: \_\_\_\_\_

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? \_\_\_\_\_ 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 **Y** for *YES* or **N** for *NO*

- |                                                   |                                                 |                                                     |                                              |
|---------------------------------------------------|-------------------------------------------------|-----------------------------------------------------|----------------------------------------------|
| <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 Ache               | <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 Cherry City 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 3/2015**

### **ADDITIONAL PEDIATRIC QUESTIONNAIRE**

1. Does your child consume any over the counter or prescription medications? If so, which ones?  
(Please include any substantial use in the past i.e., Amoxicillin for chronic ear infections)
  
2. Did your child receive any childhood Vaccines? Flu shots? Did mom receive any vaccines or flu shots during pregnancy?
  
3. Did your child suffer a reaction following a vaccine?
  
4. Does your child have confirmed food allergies?
  
5. Birth Process (C-section, natural, epidural, Pitocin, vacuum extraction, forceps, etc.) Any birth trauma or bruising on child?
  
6. Has your child had any significant slips or falls (i.e. off a swing, out of the high chair, off the bed, etc.)