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*

☐ Headaches	☐ Orthopedic Problems	☐ Digestive Disorders	☐ Behavioral Problems
☐ Dizziness	☐ Neck Problems	☐ Poor Appetite	☐ ADD/ADHD
☐ Fainting	☐ Arm Problems	☐ Stomach Ache	☐ 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 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.)