Welcome to our office!

Please fill out our Health Record as completely and accurate as possible. If you have any questions, please don't hesitate to ask one of our qualified Chiropractic Assistants.

It is our pleasure to be of service to you. Our commitment to you is to promote the highest quality of health and well-being with Chiropractic care.

Pediatric History Form

Child's First Name _____ **Child's Last Name** _____

Birthday _____ **Birth Height** _____ **Birth Weight** _____

Current Height _____ **Current Weight** _____ **Age** _____

Street Address _____

City _____ **State/Province** _____ **Zip Code** _____

Phone _____ **Mother's Cell** _____ **Father's Cell** _____

Purpose of this visit:

☐ Wellness Check-up ☐ Injury or Accident ☐ Other

Mother's DOB _____ **Father's DOB** _____

Child's Current Problem:

If your child is experiencing Pain/Discomfort please identify where, and for how long:

_____

When did this problem begin?

_____

Has this problem occurred before? **If yes, when?**

○ Yes ○ No _____

Any bowel or bladder problems since this problem began?

☐ No ☐ Yes

If yes, please explain:

_____

Have you seen other doctors for this problem?

○ No ○ Yes

Doctor's Name

_____

Approximate date of last visit?

_____

Results

_____

How is this problem NOW?

☐ Rapidly Slowly ☐ Improving Slowly ☐ About the Same ☐ Gradually Worsening ☐ On & Off

Please list any medication taken for this problem:

_____

Has your child ever sustained an injury playing organized sports?

☐ No ☐ Yes

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 applicable items

☐ Headaches	☐ Dizziness	☐ Fainting	☐ Seizures/Convulsions
☐ Heart Trouble	☐ Chronic Earaches	☐ Poor Posture	☐ Behavioral Problems
☐ Fall in Baby Walker	☐ Sleeping Problems	☐ Fall from High Chair	☐ Orthopedic Problems
☐ Neck Problems	☐ Arm Problems	☐ Leg Problems	☐ Joint Problems
☐ Backaches	☐ Hypertension	☐ Colds/Flu	☐ Fall from Bed or Couch
☐ Broken Bones	☐ Fall Off Slide	☐ Digestive Disorders	☐ Poor Appetite
☐ Stomach Aches	☐ Ruptures/Hernia	☐ Constipation	☐ Diarrhea
☐ Asthma	☐ Walking Trouble	☐ Fall from Crib	☐ Colic
☐ Fall from Changing Table	☐ Anemia	☐ ADD/ADHD	☐ Reflux
☐ Muscle Pain	☐ Growing Pains	☐ Sinus Trouble	☐ Scoliosis
☐ Bed Wetting	☐ Fall Off Swing	☐ Fall Off Bicycle	☐ Fall Off Monkey Bars

Other:

_____

Allergies to:

_____

Parent or Legal Guardian's Signature

_____

Date

_____