

# Pediatric Health History (Ages 4-12)

*Thank you for choosing chiropractic care for your child. Please complete this form in ink and print clearly. If you have any questions, do not hesitate to ask for assistance. We will be happy to help.*

Child's Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Sex: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Address: \_\_\_\_\_

Mother Name: \_\_\_\_\_ H: \_\_\_\_\_ W: \_\_\_\_\_ C: \_\_\_\_\_

Father Name: \_\_\_\_\_ H: \_\_\_\_\_ W: \_\_\_\_\_ C: \_\_\_\_\_

*Who may we thank for referring you to our office?* \_\_\_\_\_

## Insurance Information

Name of Insured: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Insured Birth Date: \_\_\_\_\_ Social Security# \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Phone: \_\_\_\_\_

Policy # \_\_\_\_\_ Group# \_\_\_\_\_

## Symptoms

Reason for seeing the doctor: \_\_\_\_\_

Specifically, where is the problem located? \_\_\_\_\_

When did you or your child first notice the symptoms? \_\_\_\_\_

What does the pain feel like?  Sharp  Dull  Aching  Throbbing  Stabbing  Shooting  
 Tingling  Numbness  Swelling  Burning  Other \_\_\_\_\_

What treatment has your child received for this condition?  Medications \_\_\_\_\_

Other \_\_\_\_\_

Other doctors seen for this condition: \_\_\_\_\_

I fully authorize Dr. \_\_\_\_\_ to examine (including x-rays) and provide treatment to my child.

I recognize that I am fully responsible for payment of all services rendered on behalf of my child.

**Signature of Parent:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Name of Pediatrician:** \_\_\_\_\_ **Date of Last Visit:** \_\_\_\_\_

Address of Pediatrician: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Dr.'s Assistant: \_\_\_\_\_

May we share our history and examination findings with this doctor?  Yes  No

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**Which conditions has your child experienced in the past 2 months:**

- |   |   |
|---|---|
| <input type="checkbox"/> Headaches _____        | <input type="checkbox"/> Frequent colds _____   |
| <input type="checkbox"/> Sinus problems _____   | <input type="checkbox"/> Diarrhea _____         |
| <input type="checkbox"/> Ear infections _____   | <input type="checkbox"/> Constipation _____     |
| <input type="checkbox"/> Breathing issues _____ | <input type="checkbox"/> Rashes _____           |
| <input type="checkbox"/> Fatigue _____          | <input type="checkbox"/> Milk intolerance _____ |
| <input type="checkbox"/> Irritability _____     | <input type="checkbox"/> Bed wetting _____      |
| <input type="checkbox"/> Hyperactivity _____    | <input type="checkbox"/> Digestive issues _____ |
| <input type="checkbox"/> Sleeping issues _____  | <input type="checkbox"/> Allergies _____        |

Other issues: \_\_\_\_\_

**Regarding your child:**

Which sports does your child participate in? \_\_\_\_\_

When and which area(s) has your child injured (ie: sprains/broken bones)?  
\_\_\_\_\_

When and for what condition has your child been hospitalized or had surgery?  
\_\_\_\_\_

Has your child ever been involved in a car accident? When? \_\_\_\_\_

Does your child take any medications? \_\_\_\_\_

How many times has your child been on antibiotics? \_\_\_\_\_

Has your child ever had a scoliosis examination by *a chiropractor*?  Yes  No

What aspects of your child's health or behavior would you like improved?  
\_\_\_\_\_