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:_____ Sex: M F Today's Date:_____

Birth Date:_____ Address:_____ Zip:_____

Mother :_____ Home Phone:_____ Work:_____ Cell:_____

Father:_____ Home Phone:_____ Work:_____ Cell:_____

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

What is your child's main health issue?_____

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:_____

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

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

- ❒ Headaches _____
- ❒ Sinus problems _____
- ❒ Ear infections _____
- ❒ Breathing issues _____
- ❒ Fatigue _____
- ❒ Irritability _____
- ❒ Hyperactivity _____
- ❒ Sleeping issues _____
- ❒ Frequent colds _____
- ❒ Diarrhea _____
- ❒ Constipation _____
- ❒ Rashes _____
- ❒ Milk intolerance _____
- ❒ Bed wetting _____
- ❒ Digestive issues _____
- ❒ 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?

_____

_____

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:_____