

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

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: \_\_\_\_\_

# Health From Within

9. Has your child ever sustained an injury playing organized sports? \_\_\_\_\_ If yes; please explain

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10. Has your child ever sustained an injury in an auto accident? \_\_\_\_\_ if yes, please explain

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## HAS YOUR CHILD EVER SUFFERED FROM: mark a Y for YES OR N N

- |   |   |   |  |
|---|---|---|--|
| <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 Aches              | <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:              |

## Pregnancy History:

Type of Birth: \_\_\_\_\_ Normal Vaginal \_\_\_\_\_ Forceps \_\_\_\_\_ Cesarean \_\_\_\_\_ Vaccum

Problems During Pregnancy: \_\_\_\_\_

Problems During Labor: \_\_\_\_\_

Was there presence of: \_\_\_\_\_ Jaundice (Yellow) \_\_\_\_\_ Cyanosis (Blue) \_\_\_\_\_ Congenital Abnormalities

Please explain: \_\_\_\_\_

## Infant History:

Eating: \_\_\_\_\_ Breast \_\_\_\_\_ Bottle \_\_\_\_\_ Formula Name: \_\_\_\_\_

Sleep: \_\_\_\_\_ hours per night Quality: \_\_\_\_\_ Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor

ER/Hospital Visits: \_\_\_\_\_

Surgeries/Medications: \_\_\_\_\_

Age of Child when: \_\_\_\_\_ Responded to sound \_\_\_\_\_ Followed an object with Eyes \_\_\_\_\_ Sit alone  
\_\_\_\_\_ Crawl \_\_\_\_\_ Stand \_\_\_\_\_ Walk alone

Age of Child experienced (if any): \_\_\_\_\_ Chicken Pox \_\_\_\_\_ Mumps \_\_\_\_\_ Measles

Vaccination History: \_\_\_\_\_ Current up to date \_\_\_\_\_ Spreading out \_\_\_\_\_ None/Exemption

Health From Within

*I understand that I am directly and fully responsible to Health From Within 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* \_\_\_\_\_