

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

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?
