G·A·R·D·E·N CHIROPRACTIC
family health & wellness center • 474-5054

[illegible]

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 _______Other (please explain below)

Please explain: ____

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: ____

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

_____

_____

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

_____

_____

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

☐ Headaches	☐ Orthopedic Problems	☐ Digestive Disorders	☐ Behavioral Problems
☐ Dizziness	☐ Neck Problems	☐ Poor Appetite	☐ ADD/ADHD
☐ Fainting	☐ Arm Problems	☐ Stomach Aches	☐ Ruptures/Hernia
☐ Seizures/Convulsions	☐ Leg Problems	☐ Reflux	☐ Muscle Pain
☐ Heart Trouble	☐ Joint Problems	☐ Constipation	☐ Growing Pains
☐ Chronic Earaches	☐ Backaches	☐ Diarrhea	☐ Allergies to_____
☐ Sinus Trouble	☐ Poor Posture	☐ Hypertension	☐ Asthma
☐ Scoliosis	☐ Anemia	☐ Colds/Flu	☐ Walking Trouble
☐ Bed Wetting	☐ Colic	☐ Broken Bones	☐ Sleeping Problems
☐ Fall in baby walker	☐ Fall from bed or couch	☐ Fall from crib	☐ Fall off swing
☐ Fall off bicycle	☐ Fall from high chair	☐ Fall off slide	☐ Fall down stairs
☐ Fall from changing table	☐ Fall off monkey bars	☐ Fall off skateboard/skates	☐ Other: _____

I understand that I am directly and fully responsible to Garden Chiropractic 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_____

JDD,DC 12/2011