Pediatric History Form

Patient Demographics **HR#: ________________**

Child's Name: _______________________________ Today's Date: _____________________________

DOB: ____/____/________ Birth Height: ________ Birth Weight: ________ Current Height: _______

Current Weight: ________ Age: _____ Address: ____

City: __________________________ State: ____ Zip Code: ____________ Phone #: __________________________

Mother's Name: _______________________________ Mother's Cell #: _________________________________

Father's Name: ________________________________ Father's Cell #: __________________________________

Pediatrician/Family MD: ____________________________________ City & State: ____________________________

Last Visit: ____/____/____ Reason for Visit: ____

Who is responsible for this bill? ____

□ Father's Social Security # _____-_____-______ □ Mother's Social Security # ______-_____-______

Pregnancy History:

Third Trimester Presentation: ____Vertex ____Breech ____Transverse ____Face/Brow

Type Of Birth: ____Normal vaginal ____Forceps ____Cesarean ____Suction Cup or Vacuum

Location: ____Home ____Hospital ____Birthing Center ____Other: __________________________________

Problems during pregnancy: ____

Problems during labor/delivery: ____

Was there presence of: ____Jaundice (yellow) ____Cyanosis (blue) ____Congenital Anomalies/Defects?

If Yes, please explain: ____

Infant History:

Infant Feeding: ____Breast ____Bottle/Formula If formula, which formula? ____________________________

Number of hours sleep per night: _____ Quality of sleep: ____Good ____Fair ____Poor

List all immunizations your child has had: ____

____

Has your child ever been treated in an emergency room? _____ If Yes, explain: ___________________________

Has your child ever had any surgeries? _____ If Yes, explain: ____

Is your child currently on any medications? _____ If Yes, please list: _______________________________________

____

At what age, if ever, did your child suffer from the following?

Chicken Pox____ Mumps____ Measles____ Rubella____ Whooping Cough____

Other_____________________________________

Child's Current Problem:

Purpose of this visit: ____ Wellness Check-up ____ Injury or Accident ____ Other

Please explain: ____

If your child is experiencing pain or discomfort, please identify where and for how long:

____

I. When did the problem first begin? Date: ____/____/____ ____N/A ____ Sudden ____Gradual

II. Have they experienced this problem before? ____No ____Yes; If Yes, when? ______________________

III. Any bowel or bladder problems since this problem began? If Yes, describe:

____

IV. Have you seen any other doctor for this problem? ____No ____Yes; If Yes, by whom?

____

V. How long ago? ____Days ____Weeks ____Months ____Years

VI. What were the results of past treatment?

____

VII. How is the problem **now**? □ Rapidly improving □Improving slowly □About the same □ Worsening

VIII. Please list any medication(s) taken for this problem:

____

IX. Has your child ever sustained an injury playing organized sports? ____No ____Yes; If Yes, please explain:

____

____

X. Has your child ever sustained an injury in an auto accident? ____No ____Yes; If Yes, please explain:

____

____

Has your child ever suffered from: *Mark a Y for yes or N for no.*

Headaches____	Orthopedic Problems____	Digestive Disorders____	Behavioral Problems____
Dizziness____	Neck Problems____	Poor Appetite____	ADD/ADHD____
Fainting____	Arm Problems____	Stomach Aches____	Ruptures/Hernias____
Seizures/Convulsions____	Leg Problems____	Reflux____	Muscle Pain____
Heart Trouble____	Joint Problems____	Constipation____	Growing Pains____
Chronic Ear Aches____	Backaches____	Diarrhea____	Allergies____ (explain below)
Sinus Trouble____	Poor Posture____	Hypertension____	Asthma____
Scoliosis____	Anemia____	Colds/Flu____	Walking Trouble____
Bed Wetting____	Colic____	Broken Bones____	Sleeping Problems____
Fall in walker/stroller___	Fall from couch/bed____	Fall from crib____	Fall off swing____
Fall off bicycle____	Fall from high chair____	Fall off slide____	Fall down stairs____

Fall from changing table____ Other: ____

Allergies:

____

____

____

I understand that I am directly and fully responsible to True Health 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 legal right to select and authorize health care services on behalf of.

____ _____________________________

Parent or Legal Guardian's Signature Date

____ _____________________________

Doctor's Signature Date

Consent To Treat A Minor

Patient's Name: ______________________________ DOB: ________________________

I understand that like the prescription drugs, surgery and all other forms of medical care, chiropractic care holds some risks. These risks have been discussed with me to my complete satisfaction and I have conveyed my understanding of these risks to the doctor and after careful consideration, I hereby consent my child to be treated by Dr. Lonnie Bagwell or any other licensed providers associated with or substituting for him now or any time over the course of my child's care. Further, I wish to rely on the doctor to exercise judgement during the course of any portion of my child's care to add or remove procedures, which he feels at the time, based on fact then known, is in my child's best interest.

□ 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/Legal Guardian Signature Date

____ ___________________________

Witness Date