THOMPSON CHIROPRACTIC CLINIC

PEDIATRIC HISTORY FORM

PATIENT DEMOGRAPHICS

Childs Name____ Today's Date _____/_____/______

Date of Birth _____/_____/______ Current Height: _________ Current Weight: _________

Address __________________________________ City ____________________ State _____ Zip ________

Phone (Home) _______________________ Secondary Phone: _______________________

Mother_________________________ DOB____/____/_______

Father_______________________DOB____/____/______

Pediatrician/Family MD _______________________________City & State ______________________ Last Visit: ____/____/____

Who is responsible for payments to this office for services rendered?

☐ Father Social Security # ______-______-_______

☐ Mother Social Security # _______-______-_______

☐ Other *(please explain):* ____

CHILD'S CURRENT PROBLEM:

Purpose of this visit: _____Wellness Check-up _____Injury or Accident _____Other: 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? ☐ No ☐ 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? ☐ No ☐ Yes If yes; please explain ____ ____
10. Has your child ever sustained an injury in an auto accident? ☐ No ☐ Yes If yes; please explain ____

HAS YOUR CHILD EVER SUFFERED FROM: mark **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/Hernia
☐ Seizures	☐ 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	☐ Other: ______________________		

I understand that I am directly and fully responsible to Thompson Chiropractic Clinic 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_________________