

# PEDIATRIC HISTORY FORM

## PATIENT DEMOGRAPHICS

HR#: \_\_\_\_\_

Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Child's Name \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_

Birth Height: \_\_\_\_\_ Birth Weight: \_\_\_\_\_ Current Height: \_\_\_\_\_ Current Weight: \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_ Phone (Home) \_\_\_\_\_

Mother's Name: \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Mother's Mobile \_\_\_\_\_

Father's Name: \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Father's Mobile \_\_\_\_\_

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: \_\_\_\_\_

*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? \_\_\_ 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:** *Check all that apply*

- |   |   |   |  |
|---|---|---|--|
| <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"/> Asthma              |
| <input type="checkbox"/> Sinus Trouble            | <input type="checkbox"/> Poor Posture           | <input type="checkbox"/> Hypertension               | <input type="checkbox"/> Walking Trouble     |
| <input type="checkbox"/> Scoliosis                | <input type="checkbox"/> Anemia                 | <input type="checkbox"/> Colds/Flu                  | <input type="checkbox"/> Sleeping Problems   |
| <input type="checkbox"/> Bed Wetting              | <input type="checkbox"/> Colic                  | <input type="checkbox"/> Broken Bones               | <input type="checkbox"/> Fall off swing      |
| <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 down stairs    |
| <input type="checkbox"/> Fall off bicycle         | <input type="checkbox"/> Fall from high chair   | <input type="checkbox"/> Fall off slide             |  |
| <input type="checkbox"/> Fall from changing table | <input type="checkbox"/> Fall off monkey bars   | <input type="checkbox"/> Fall off skateboard/skates |  |

Allergies to \_\_\_\_\_

Other: \_\_\_\_\_

I understand that I am directly and fully responsible to [Covington Family Chiropractic LLC](#) 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's Signature

\_\_\_\_\_  
Date