

**LAKWOODS CHIROPRACTIC
PEDIATRIC HISTORY FORM**

PATIENT DEMOGRAPHICS	HR#: _____
Child's Name _____ Today's Date ____/____/____	
Date of Birth ____/____/____ Birth Height: _____ Birth Weight: _____ Current Height: _____	
Current Weight: _____ Age: _____ Address _____	
City _____ State _____ Zip _____ Phone (Home) _____	
Mother's Name: _____ Mother's Mobile _____ DOB ____/____/____	
Father's name: _____ Father's Mobile _____ DOB ____/____/____	
Pediatrician/Family MD _____ City & State _____	
Last Visit: ____/____/____ Reason for visit: _____	
Who is responsible for this bill? _____	
<input type="checkbox"/> Father's Social Security # _____ - _____ - _____ <input type="checkbox"/> Mother's Social Security # _____ - _____ - _____	
<input type="checkbox"/> 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? _____ 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: *Please check if symptoms have occurred in the past or present*

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

I understand that I am directly and fully responsible to [Lakewoods 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 5/2011