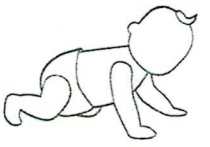
Pediatric HISTORY OF PRESENT CONCERNS



Child's Name:_____Age:_____Date of Birth:_____Sex: M F

Street Address:_____City, ST, Zip:_____

Parent's Names:_____

Phone:_____Email:_____

Whom may we thank for referring you to our office?_____

Reason for coming to our office:_____

Name of Person Responsible for the Account:_____

Relationship to Patient:_____Preferred Phone #:_____

Address (if different than above):_____

Insurance Company:_____Name of Insured:_____

Relationship to Patient:_____Date of Birth:_____

Present Health Challenge(s)

For what health challenge(s) is your child here for? When did it begin?

_____

Has your child seen other health care practitioners for this? What did they recommend?

_____

What was the outcome of prior treatment/recommendations?

_____

Health History

Symptoms: Please check any current or past problems your child has on the list below:

__Anemia
__Arthritis
__ADHD
__Allergies
__Anxiety
__Arm/Elbow Pain
__Asthma
__Autism
__Backaches
__Behavioral Issues
__Bed Wetting
__Blood disorders
__Broken bones:_____
__Chest Pain
__Chronic Earaches
__Colic
__Concussions
__Constipation
__Convulsions
__Cough/Wheeze
__Diabetes
__Diarrhea
__Digestive Problems
__Dizziness
__Eczema
__Fainting
__Fever/Chills
__Frequent Colds
__Growing pains
__Headaches
__Heart Condition
__Hernias
__Hyperactivity
__Hypertension
__Joint Pain
__Insomnia
__Itchy Eyes
__Knee/Foot Pain
__Leg/Hip Pain
__Muscle Pain
__Neck Pain
__Nightmares
__Poor Appetite
__Poor Memory
__Rashes
__Reflux/Spitting up
__Runny Nose
__Scoliosis
__Sinus Trouble
__Sprains/Strains
__Stomach Aches
__Unusual Moles
__Other_____

Name of Pediatrician:_____Date of Last Visit:_____

Current Medications & Vitamins:_____

Past Trauma (falls, sports injuries, accidents, etc)_____

Past Surgeries:_____

Prenatal History

Location of Birth: ___ Home ___ Birthing Center ___ Hospital

Complications during pregnancy: Y - N List: _____

Medications during pregnancy/delivery: _____

Cigarette / Alcohol use during pregnancy: Y - N

Birth intervention: ___ Forceps ___ Vacuum ___ Caesarian

Complications during delivery: Y - N List: _____

Birth weight_____ Birth length_____

Feeding history

Breast Fed: Y - N How long'?_____ Formula fed: Y - N How long'?_____ Type:_____

Introduced to cereal at____months. Solids at _____ months. Cow's milk at _____ months

Food / juice allergies or intolerances Y - N List: _____

Developmental History

Sleep (Hrs per night) _____ Problems sleeping _____

Medical/Vaccination History

Has your child ever had an adverse reaction to a prescription or over-the-counter medication? Y - N

If yes, please

explain:_____

Has your child been vaccinated? Y - N Adverse reactions to any

vaccine?_____

Childhood Diseases

___Chicken Pox : Age ____ * ___ Mumps: Age ____ * ___ Rubella: Age ____ * ___ Whooping cough: Age ____

___ Measles: Age ____ * ___ Meningitis: Age ____ * ___ Tuberculosis: Age ____ * ___ Other: Age ____

CONSENT FOR TREATMENT OF MINOR

I hereby certify that the information I have provided is correct and accurate, to the best of my knowledge.

I, _____ , as the parent/guardian of this child, _____ , hereby grant permission for my child to receive examination and chiropractic treatment as deemed necessary.

_____ _____

Signature of Parent or Guardian Date