

PEDIATRIC HISTORY FORM

Patient Information

First Name: _____ MI: _____ Last Name: _____ Today's Date: ____/____/____
 Date of Birth: ____/____/____ Current Height: _____ Current Weight: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Primary Phone: () _____ Secondary/Mobile Phone: () _____
 Mother: _____ Date of Birth: ____/____/____
 Father: _____ Date of Birth: ____/____/____
 Pediatrician/Family MD: _____ City & State: _____ Last Visit: ____/____/____
 Who is responsible for payments to this office for services rendered?
 Father SSN: _____ - _____ - _____ Mother SSN: _____ - _____ - _____
 Other (please explain): _____

Patient Condition

Reason(s) for visit: Wellness Check-up Injury or Accident Other: _____

 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? _____
 How long ago? _____ Days _____ Weeks _____ Months _____ Years
 What were the results of past treatment? _____
 5. How is this problem now?
 Rapidly improving Improving slowly About the same Gradually Worsening On & Off
 6. Please list any medication(s) taken for this problem: _____
 7. Has your child ever sustained an injury playing organized sports? No Yes If yes, please explain: _____

 8. Has your child ever sustained an injury in an auto accident? No Yes If yes, please explain: _____

 9. Any other significant injuries or surgeries? No Yes If yes, please explain: _____

Allergies

Are you allergic to any medication(s)? Yes No If yes, list medications: _____

 Other known allergies:
 Latex Shellfish Peanuts Dairy Other: _____
 Reaction(s): _____

Immunizations

<input type="checkbox"/> All recommended vaccines	<input type="checkbox"/> Influenza	<input type="checkbox"/> Tetanus
<input type="checkbox"/> Adenovirus	<input type="checkbox"/> IPV (polio)	<input type="checkbox"/> Varivax (chicken pox)
<input type="checkbox"/> DTaP (diphtheria, tetanus, pertussis)	<input type="checkbox"/> MMR (measles, mumps, rubella)	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Haemophilus B	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Not vaccinated
<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Rotavirus	

Personal Health History

<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	<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(s) Please specify: _____			
<input type="checkbox"/> Other: _____			

I understand that I am directly and fully responsible to Ascherl Chiropractic Sports & Wellness 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 my doctor. After careful consideration I do hereby request, and authorize imaging studies (only if necessary), 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.

Under 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.

Patient or Legal Guardian's Signature	Relationship to patient	Date
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Doctor's Signature	Date Reviewed
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