EAST VALLEY CHIROPRACTIC
PEDIATRIC HISTORY FORM

PATIENT DEMOGRAPHICS HR#:_____

Today's Date _____/_____/____

Childs 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)*: _____

INSURANCE INFORMATION

Who is responsible for this account? _____ Relationship to patient:_____

Insurance Co:_____ID#_____

Subscriber Name _____Birthdate:_____

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*

☐ Headaches	☐ Orthopedic Problems	☐ Digestive Disorders	☐ Behavioral Problems
☐ Dizziness	☐ Neck Problems	☐ Poor Appetite	☐ ADD/ADHD
☐ Fainting	☐ Arm Problems	☐ Stomach Aches	☐ Ruptures/Hernia
☐ Seizures/Convulsions	☐ Leg Problems	☐ Reflux	☐ Muscle Pain
☐ Heart Trouble	☐ Joint Problems	☐ Constipation	☐ Growing Pains
☐ Chronic Earaches	☐ Backaches	☐ Diarrhea	☐ Asthma
☐ Sinus Trouble	☐ Poor Posture	☐ Hypertension	☐ Walking Trouble
☐ Scoliosis	☐ Anemia	☐ Colds/Flu	☐ Sleeping Problems
☐ Bed Wetting	☐ Colic	☐ Broken Bones	☐ Fall off swing
☐ Fall in baby walker	☐ Fall from bed or couch	☐ Fall from crib	☐ Fall down stairs
☐ Fall off bicycle	☐ Fall from high chair	☐ Fall off slide	
☐ Fall from changing table	☐ Fall off monkey bars	☐ Fall off skateboard/skates	

☐ Allergies to_____

☐ Other: _____

I understand that I am directly and fully responsible to East Valley 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.

☐ I do hereby state that I have legal custody of the aforementioned Minor. I grant my authorization and consent for East Valley Chiropractic to administer treatment to my child.

_____ _____

Parent or Legal Guardian's Signature Date

_____ _____

Doctor's Signature Date