INFINITE health center

PEDIATRIC HISTORY FORM

PATIENT DEMOGRAPHICS

Childs Name_____ Today's Date__/_____/____ HR#:_____

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 __/_____/____

Fathers name:_____Father's Mobile_____DOB____/____/____

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? (Y / N). If yes, (Describe): _____
4. Have you seen any other doctors for this problem? ☐ No ☐Yes If yes who? _____
5. What were the results of past treatment? _____
6. Since the problem started, it is: ☐Rapidly Improving ☐Improving Slowly ☐Same ☐Gradually Worsening ☐On & Off
7. Please list any medication taken for this problem: _____

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 Ache	☐ Ruptures/Hernia
☐ Seizures/Convulsions	☐ Leg Problems	☐ Reflux	☐ Muscle Pain
☐ Heart Trouble	☐ Joint Problems	☐ Constipation	☐ Growing Pains
☐ Chronic Earaches	☐ Backaches	☐ Diarrhea	☐ Allergies to_____
☐ Sinus Trouble	☐ Poor Posture	☐ Hypertension	☐ Asthma
☐ Scoliosis	☐ Anemia	☐ Colds/Flu	☐ Walking Trouble
☐ Bed Wetting	☐ Colic	☐ Broken Bones	☐ Sleeping Problems
☐ Fall in baby walker	☐ Fall from bed or couch	☐ Fall from crib	☐ Fall off swing
☐ Fall off bicycle	☐ Fall from high chair	☐ Fall off slide	☐ Fall down stairs
☐ Fall from changing table	☐ Fall off monkey bars	☐ Fall off skateboard/skates	☐ Other: _____

Daily we experience physical, chemical, and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual and begin very early in life. Answering these questions will give us information that will allow us to better assess the challenges to your child's health potential.

Pregnancy:

Were there any complications to the pregnancy? _____

Was mom on any medications, prescriptions, or over-the-counter? □ Yes □No

If yes, explain: _____

Did Mom or Dad smoke during pregnancy? □ Yes □ No

Was the baby ever in the Breech position? □Yes □ No

How many ultrasounds performed? _____

Birth and Delivery:

Where was the baby born? □ Home □ Hospital □ Birthing Center □ Other: _____

Was the delivery: □ Vaginal □ C-Section Were any devices used? □ Forceps □ Vacuum

How long was labor? _____ How long was the delivery? _____

Was oxytocin / Pitocin used? □ Yes □ No Was an epidural administered? □ Yes □ No

Infancy:

Was the infant vaccinated? □ Yes □ No If yes, any reactions/changes after? _____

Was there any prolonged use of medicines or an inhaler? □Yes □No If yes, which? _____

Did the infant suffer any traumas such as serious falls or car accidents? □ Yes □ No

Childhood Years:

Did the child have any childhood illnesses? □ Yes □ No Explain: _____

Did the child play youth sports? □ Yes □ No Which Sport(s)? _____

Has the child had any surgery? □ Yes □ No Explain: _____

Has the child fallen from a height over 3 feet? □ Yes □ No Explain: _____

Was the child involved in any car accidents? □ Yes □ No Explain: _____

Has there been any prolonged use of medications? □ Yes □ No Explain: _____

Has the child suffered emotional traumas? □ Yes □ No Explain: _____

Please provide us any other health information you feel would be helpful: _____

_____

I understand that I am directly and fully responsible to Infinite Health Center 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 3/2015