MONARCH chiropractic

Pediatric History Form

PATIENT DEMOGRAPHICS:

Name:_____ Today's Date:_____/_____/

DOB: __-__-__ Birth Height:_____Birth Height:_____Current Weight: _____

Current Height:_____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: _____

Other Pertinent Information (Please Explain): _____

_____

CHILD'S CURRENT HEALTH STATUS:

Purpose for 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 the 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? ❍ Yes ❍ No
   If yes, please describe: _____
   _____
10. Has your child ever sustained an injury in an auto accident? ❍ Yes ❍ No
    If yes, please describe: _____
    _____

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HAS YOUR CHILD EVER SUFFERED FROM: (Check all that apply)

___ Headaches	___Orthopedic Problems	___Digestive Disorder	_____Behavioral Issues
___ 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 Aches	___Backaches	___Diarrhea	___Allergies
___ 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 crib/bed	___Fall from couch	___Fall off swing
___ Fall off bicycle	___Fall from high chair	___Fall from slide	___Fall down stairs
___ Fall from changing table	___Fall from jungle gym	___Fall off skates/board	___ Other: _____

BIRTH EXPERIENCE:

Normal/Natural Birth? ❍Yes ❍ No If No, please explain: _____

Medical Intervention: ❍ None ❍ C-Section ❍ Epidural ❍ Forceps ❍ Vacuum ❍ Other: _____

Birth Trauma? ❍Yes ❍ No If No, please explain: _____

Vaccine Schedule: ❍ None ❍ Delayed Schedule ❍ Full Schedule Up to Date

I understand that I am directly and fully responsible to Monarch 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 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 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

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