MOSS FAMILY CHIROPRACTIC

PEDIATRIC HISTORY FORM

PATIENT DEMOGRAPHICS

Childs Name_____ Today's Date _____/_____/____

Date of Birth _____/_____/_____ Birth Height: _____ Birth Weight: _____ Current Height: _____

Current Weight: _____ Age: _____ Address _____

City _____ State _____ Zip _____ Phone (Home) _____

Mothers Name: _____Mother's phone number _____DOB____/____/____

Fathers name: _____Father's phone number _____DOB ____/____/____

Pediatrician/Family MD _____City & State _____

Last Visit: ____/____/____ Reason for visit:_____

Financially Responsible Party? Mother Father Other:_____

Financially Responsible Party's Social Security # _____-_____-_____

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? Yes No If yes when? _____
3. Any bowel or bladder problems since this problem began? Yes No
   If yes please describe:_____
4. Have you seen any other doctors for this problem? Yes No 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? Yes No

   If yes, please explain _____

   _____
10. Has your child ever sustained an injury in an auto accident? Yes No

    If yes, please explain_____

    _____

Childs Name_____ Today's Date _____/_____/____

HAS YOUR CHILD EVER SUFFERED FROM (please 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	☐ 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: _____

WE ARE HERE TO SERVE YOU AND ECOURAGE YOU TO ASK QUESTIONS. YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR CHILD'S RESULTS.

AUTHORIZATION FOR CARE OF MINOR

I understand that I am directly and fully responsible to Moss Family Chiropractic for all fees associated with the chiropractic care my child receives. I hereby authorize this office and its Doctors to administer care to my Son/Daughter as they deem necessary.

_____ _____
Parent or Legal Guardian's Signature Date

_____ _____
Doctor's Signature Date