Cherry Family Chiropractic

Pediatric History Form

HR#:_____

PATIENT DEMONGRAPHICS **Todays Date: ____/____/____**

Childs Name_____ Date of Birth _____/_____/_____ Age: ____

Address _____ City _____ State _____ Zip _____

Mothers Name: _____ Phone (Home) _____ Mothers mobile:_____

Address _____ City _____ State _____ Zip _____

Fathers Name: _____ Phone (Home) _____ Fathers mobile: _____

Address _____ City _____ State _____ Zip _____

Mothers DOB_____/_____/_____ Fathers DOB_____/_____/_____

Who is responsible for payment? ☐ Father Social Security # _____-_____-_____ ☐ Mother Social Security # _____-____-_____
☐ Other *(please explain):*
If the child is insured under any health care plan who insures the child? _____

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 _____

When did the Problem first begin? Date ____/____/_____ _____Unknown _____Gradual _____Sudden

Ever had this problem **before**? ☐ No ☐ Yes If yes when? _____

Any **bowel or bladder** problems since this problem began?: No Yes *(Describe)*:_____

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? _____

How is this problem **NOW:** ☐ Rapidly Improving ☐ Improving Slowly ☐ About the Same ☐ Gradually Worsening ☐ On & Off

Please list any **medication taken** for this problem: _____
_
Has your child ever sustained an injury playing organized sports? _____ If yes; please explain: _____
Has your child ever sustained an injury in an auto accident? _____ if yes; please explain:
_____

Pediatrician/Family MD _____Phone No._____ Last Visit: ____/____/____

HAS YOUR CHILD EVER SUFFERED: mark a **Y** for **YES** OR **N** for **NO**

☐ 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	
☐ 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: _____

PREGNANCY HISTORY:

Third Trimester Presentation: _____Vertex _____Breech _____Transverse _____Face/Brow

Type of Birth: _____Normal vaginal _____Forceps _____Cesarean _____Suction Cap or Vacuum
Location: _____Home _____Hospital _____Birthing Center _____Other:_____

Problems during Pregnancy: _____

Problems during Labor/Delivery: _____

Was there presence of: _____ Jaundice? (Yellow) _____ Cyanosis? (Blue) _____ Congenital Anomalies/ Defects?

If yes, please explain: _____

INFANT HISTORY:

Birth Height: _____ Birth Weight: _____ Current Height: _____ Current Weight: _____

Infant feeding: _____Breast _____Bottle If Bottle; which Formula? _____

Number of Hours sleep per night _____ Quality of Sleep: _____Good _____Fair _____Poor

List all **IMMUNIZATIONS** you child has had

_____

Has your child ever been treated at the emergency room? _____ if yes; please explain

_____

Has your child ever been hospitalized? _____ if yes; please explain

_____

Has your child ever had any Surgeries? _____ if yes; please explain

_____

Is your child currently on any medication? _____ if yes; please list:

_____

AT WHAT AGE DID THE CHILD: Respond to sound _____ Follow an object with his/her eyes _____ Sit alone _____
Hold head up _____ Crawl _____ Stand _____ Walk alone _____

AT WHAT AGE, IF EVER, DID CHILD SUFFER FROM THE FOLLOWING:
Chicken pox ❑ YES ❑ NO Mumps ❑ YES ❑ NO Measles ❑ YES ❑ NO Rubella ❑ YES ❑ NO

FAMILY HISTORY:

Please indicate if your child or a family member has had any of the following: Write "**C**" for **child** or "**F**" for **family member**:

____ Heart Disease	____ Diabetes	____ Stroke
____ Cancer	____ High / Low blood pressure	____ Asthma
____ Gastrointestinal disease	____ Memory/mood disorder	____ Thyroid problem

Other facts concerning the health of any other family members which may or may not be relevant to your child's current state of health, but that you feel you would like the doctor to be aware of?

_____

I understand that I am directly and fully responsible to Cherry Family Chiropractic for all fees associated with chiropractic care my child receives. It has been explained to me that all fees paid for x-rays taken at this office are for the examination, and that I am only entitled to a copy of the written imaging report, which explains the results of my child's examination. The actual films themselves are considered part of my child's original health record and as such will not be released to anyone, under any circumstances, including me. I further understand and agree that they are **the sole legal property** of this practice and that by law the doctor must, retained these films for a period of no less than two years.

☐ 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