CARDINAL CHIROPRACTIC
13648 Orchard Parkway, Ste 800, Westminster, CO 80023 (303) 953-7888 info@cardinalfamilychiro.com

PEDIATRIC HISTORY FORM

PATIENT DEMOGRAPHICS HR#:_____

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 Mobile _____DOB____/____/____

Fathers name: _____ Father's Mobile _____ DOB ____/____/____

Pediatrician/Family MD: _____ City & State: _____

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

Who is responsible for this bill/finances? _____ Relationship: _____

☐ 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 p**roblem 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?: [ ] No [ ] Yes
   If yes, please *Describe*:

_____

_____

4. Have you seen any **other doctors** for this problem? [ ] No [ ] Yes
   If yes who? _____
5. How long ago did this problem begin?
   _____ Days _____ Weeks _____ Months _____Years
6. What were the results of past treatment? _____

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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: (*Mark* **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 off monkey bars	□ Fall from changing table	□ Fall off skateboard/skates	

□ Other: _____
_____

I understand that I am directly and fully responsible to Cardinal 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.

_____ _____
Parent or Legal Guardian's Signature Date

Doctor Signature: _____ Date_____

JDD,DC 5/2011