LEGACY FAMILY CHIROPRACTIC

PEDIATRIC HISTORY FORM

PATIENT DEMOGRAPHICS Today's Date _____/_____/____

Child's Name_____ Date of Birth _____/_____/_____

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

Address _____ City _____ State _____ Zip _____

Phone (Home) _____ Mother's mobile: _____ Father's mobile: _____

Mother_____ DOB_____/_____/_____ Father _____ DOB_____/_____/_____

Pediatrician / Primary Dr _____ City & State _____ Last Visit: ____/____/____

Do you have health insurance? YES NO Name of Company: _____

Who is responsible for this bill? ☐ Father Social Security # _____-_____-_____ ☐ Mother 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 _____ 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?: ☐ No ☐ Yes Describe:_____
4. Have you seen any other doctors for this problem? ☐ No ☐ Yes If yes, who and how long ago: _____
   _____
5. What were the results of past treatment? _____
6. How is this problem NOW**:** ☐ Rapidly Improving ☐ Improving Slowly ☐ About the Same ☐ Gradually Worsening ☐ On & Off
7. 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_____
_____

Name of Previous Chiropractor: _____ ☐ **N/A**
How long were you under care?_____ What were the results:_____

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: _____	

I understand that I am directly and fully responsible to Legacy 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 retain these films for a period of no less than four (4) years.

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