

Whom may we thank for referring you to our office? \_\_\_\_\_

## EASLEY FAMILY CHIROPRACTIC

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## PEDIATRIC HISTORY FORM

Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security # \_\_\_\_-\_\_\_\_-\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone (Home) \_\_\_\_\_ Mothers mobile: \_\_\_\_\_ Fathers mobile: \_\_\_\_\_

Mother \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Father \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

Pediatrician/Family MD \_\_\_\_\_ City & State \_\_\_\_\_ Last Visit: \_\_\_\_/\_\_\_\_/\_\_\_\_

Purpose of last visit \_\_\_\_\_

Birth Height: \_\_\_\_\_ Birth Weight: \_\_\_\_\_ Current Height: \_\_\_\_\_ Current Weight: \_\_\_\_\_ M: \_\_\_ F: \_\_\_ Age: \_\_\_\_\_

Ever been under chiropractic care?  No  Yes: Who/When? \_\_\_\_\_

Who is responsible for this bill?  Mother  Father  Other (*please explain*) \_\_\_\_\_

Insurance Company \_\_\_\_\_

### 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:

**Infant feeding:** \_\_\_\_\_ Breast \_\_\_\_\_ Bottle If Bottle, which Formula? \_\_\_\_\_

Number of Hours sleep per night \_\_\_\_\_ Quality of Sleep: \_\_\_\_\_ Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor

List all **IMMUNIZATIONS** your 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 \_\_\_\_\_ Hold heel up \_\_\_\_\_  
Sit Alone \_\_\_\_\_ Crawl \_\_\_\_\_ Stand \_\_\_\_\_ Walk alone \_\_\_\_\_

### AT WHAT AGE, IF EVER, DID CHILD SUFFER FROM THE FOLLOWING:

Chicken pox \_\_\_\_\_ Mumps \_\_\_\_\_ Measles \_\_\_\_\_ Rubella \_\_\_\_\_  
Whooping Cough \_\_\_\_\_ Other: \_\_\_\_\_

### HAS YOUR CHILD EVER SUFFERED FROM?

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Headaches            | <input type="checkbox"/> Orthopedic Problems | <input type="checkbox"/> Digestive Disorders | <input type="checkbox"/> Behavioral Problems |
| <input type="checkbox"/> Dizziness            | <input type="checkbox"/> Neck Problems       | <input type="checkbox"/> Poor Appetite       | <input type="checkbox"/> ADD/ADHD            |
| <input type="checkbox"/> Fainting             | <input type="checkbox"/> Arm Problems        | <input type="checkbox"/> Stomach Aches       | <input type="checkbox"/> Ruptures/Hernia     |
| <input type="checkbox"/> Seizures/Convulsions | <input type="checkbox"/> Leg Problems        | <input type="checkbox"/> Reflux              | <input type="checkbox"/> Muscle Pain         |
| <input type="checkbox"/> Heart Trouble        | <input type="checkbox"/> Joint Problems      | <input type="checkbox"/> Constipation        | <input type="checkbox"/> Growing Pains       |
| <input type="checkbox"/> Chronic Earaches     | <input type="checkbox"/> Backaches           | <input type="checkbox"/> Diarrhea            | <input type="checkbox"/> Allergies to _____  |
| <input type="checkbox"/> Sinus Trouble        | <input type="checkbox"/> Poor Posture        | <input type="checkbox"/> Hypertension        | <input type="checkbox"/> Allergies to _____  |
| <input type="checkbox"/> Asthma               | <input type="checkbox"/> Scoliosis           | <input type="checkbox"/> Anemia              | <input type="checkbox"/> Allergies to _____  |
| <input type="checkbox"/> Colds/Flu            | <input type="checkbox"/> Walking Trouble     | <input type="checkbox"/> Bed Wetting         | <input type="checkbox"/> Other: _____        |
| <input type="checkbox"/> Colic                | <input type="checkbox"/> Broken Bones        | <input type="checkbox"/> Sleeping Problems   | <input type="checkbox"/> Other: _____        |

**HAS YOUR CHILD EVER SUFFERED THE FOLLOWING SPINAL TRAUMAS?**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Fall in baby walker      | <input type="checkbox"/> Fall from bed or couch | <input type="checkbox"/> Fall off skateboard or skates |
| <input type="checkbox"/> Fall from crib           | <input type="checkbox"/> Fall off swing         | <input type="checkbox"/> Fall off bicycle              |
| <input type="checkbox"/> Fall from high chair     | <input type="checkbox"/> Fall off slide         | <input type="checkbox"/> Fall down stairs              |
| <input type="checkbox"/> Fall from changing table | <input type="checkbox"/> Fall off monkey bars   | <input type="checkbox"/> Other: _____                  |

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 \_\_\_\_\_

**FAMILY HISTORY:**

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

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

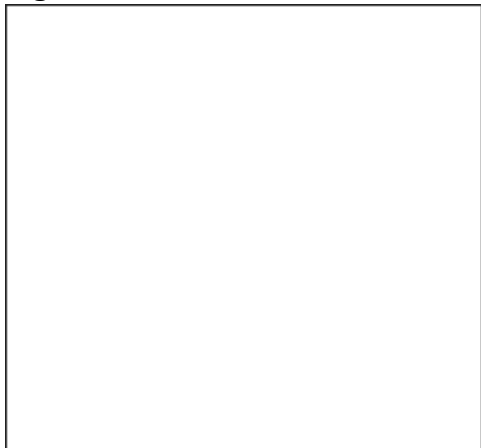
**CHILD'S CURRENT PROBLEM:**

**Purpose of this visit:** \_\_\_\_\_ Wellness \_\_\_\_\_ Check-up \_\_\_\_\_ Other: \_\_\_\_\_  
 \_\_\_\_\_ Pain/Discomfort; explain \_\_\_\_\_  
 \_\_\_\_\_ Injury; explain \_\_\_\_\_

*Please indicate precisely the area of*

*Symptoms using "XXX" on the*

*Figures below:*



**\*\*Answer to the best of your ability according to the child's age\*\***

**What type of pain are you having?  
(Circle all that apply)**  
 Pain Numbness Swelling Headaches Muscle Spasm  
 Other \_\_\_\_\_

**Quality of pain:  
(Circle all that apply)**  
 Sharp Dull Aching Throbbing Crushing Stabbing  
 Sinus Migraine Hormonal Radiating Local Other \_\_\_\_\_

**Timing of the pain (circle one):**  
 Constant Frequent On and Off Infrequent

**Severity of pain (circle one):**  
 1 being no pain, 10 being disabled  
 1 2 3 4 5 6 7 8 9 10

**If due to Pain/Discomfort/Injury, please fill out:**

1. **Onset** of Problem: 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. Any **medication taken** for this problem? No Yes: \_\_\_\_\_
5. Have you seen any **other doctors** for this problem? No Yes: \_\_\_\_\_
6. How is this problem **NOW**: Rapidly Improving Improving Slowly About the Same Gradually Worsening On & Off

I understand that I am directly and fully responsible to Easley Family Chiropractic for all 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 7 years.

I hereby authorize this office and its Doctor(s) to administer care, as they so deem necessary to my son/daughter

\_\_\_\_\_  
Parent's or Legal Guardian's Signature

\_\_\_\_\_  
Date