

Blumsack Family Chiropractic, LLC
PEDIATRIC HISTORY FORM

Today's Date: _____

HR#: _____

PATIENT DEMOGRAPHICS

Child's Name: _____ Birthdate: _____ - _____ - _____ Age: _____ Male Female

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

Address: _____ City: _____ State: _____ Zip: _____

Mother's Name: _____ Birthdate: _____ - _____ - _____

Mother's Phone: Home _____ Work _____ Mobile _____

Father's Name: _____ Birthdate: _____ - _____ - _____

Father's Phone: Home _____ Work _____ Mobile _____

Pediatrician/Family MD: _____ City/State: _____

Last Visit Date: _____ - _____ - _____ Reason for visit: _____

Who is responsible for this bill? _____

Father's Driver's License #: _____ Mother's Driver's License #: _____

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 problem first begin? Date: _____ - _____ - _____ Unknown Gradual Sudden

2. Has this problem occurred before? No Yes If yes, when? _____

3. Any bowel or bladder problems since this problem began? No Yes **If yes**, describe: _____

4. Have you seen any other doctors for this problem? No Yes **If yes**, whom? _____

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 and Off

8. Please list any medication(s) taken for this problem: _____

9. Has your child ever sustained an injury playing organized sports? No Yes **If yes**, please explain:

PATIENT'S NAME: _____ HR#: _____ DATE: _____

10. Has your child ever sustained an injury in an auto accident? No Yes **If yes, please explain:**

HAS YOUR CHILD EVER SUFFERED FROM - Check all that apply

- | | | | |
|--|--|--|---|
| <input type="radio"/> Headaches | <input type="radio"/> Orthopedic Problems | <input type="radio"/> Digestive Disorders | <input type="radio"/> Behavioral Problems |
| <input type="radio"/> Dizziness | <input type="radio"/> Neck Problems | <input type="radio"/> Poor Appetite | <input type="radio"/> ADD/ADHD |
| <input type="radio"/> Fainting | <input type="radio"/> Arm Problems | <input type="radio"/> Stomach Aches | <input type="radio"/> Ruptures/Hernia |
| <input type="radio"/> Seizures/Convulsions | <input type="radio"/> Leg Problems | <input type="radio"/> Reflux | <input type="radio"/> Muscle Pain |
| <input type="radio"/> Heart Trouble | <input type="radio"/> Joint Problems | <input type="radio"/> Constipation | <input type="radio"/> Growing Pains |
| <input type="radio"/> Chronic Earaches | <input type="radio"/> Backaches | <input type="radio"/> Diarrhea | <input type="radio"/> Asthma |
| <input type="radio"/> Sinus Trouble | <input type="radio"/> Poor Posture | <input type="radio"/> Hypertension | <input type="radio"/> Walking Trouble |
| <input type="radio"/> Scoliosis | <input type="radio"/> Anemia | <input type="radio"/> Colds/Flu | <input type="radio"/> Sleeping Problems |
| <input type="radio"/> Bed Wetting | <input type="radio"/> Colic | <input type="radio"/> Broken Bones | <input type="radio"/> Fall off swing |
| <input type="radio"/> Fall in baby walker | <input type="radio"/> Fall from bed or couch | <input type="radio"/> Fall from crib | <input type="radio"/> Fall down stairs |
| <input type="radio"/> Fall off bicycle | <input type="radio"/> Fall from high chair | <input type="radio"/> Fall off slide | |
| <input type="radio"/> Fall from changing table | <input type="radio"/> Fall off monkey bars | <input type="radio"/> Fall off skateboard/skates | |
| <input type="radio"/> Allergies to _____ | | | |
| <input type="radio"/> Other: _____ | | | |

I understand that I am directly and fully responsible to Blumsack Family Chiropractic, LLC 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 Completed

Doctor's Signature

_____-_____-_____
Date Form Reviewed