DuPage Healthcare Ltd

PEDIATRIC HISTORY FORM

PATIENT DEMOGRAPHICS

Child's Name_____ Today's Date _____/_____/____

Date of Birth _____/_____/_____ Age: _____ ☐ Male ☐ Female
Birth Height: _____ Birth Weight: _____ Current Height: _____ Current Weight: _____
Address _____ City _____ State _____ Zip _____
Phone (Home) _____ Mother's mobile: _____ Father's mobile: _____

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

Pediatrician/Family MD _____City & State _____ Last Visit: ____/____/____

Do you have health insurance? YES NO
Name of Company? _____ Name of person on Insurance: _____
Name of Secondary? _____ Name of person on Secondary: _____
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 and 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? _____

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 & Off?
8. Please list any medication taken for this problem: _____
9. Has your child ever sustained an injury playing organized sports? _____ if yes, please explain _____
10. 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: Y=Yes N=No

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

I understand that I am directly and fully responsible to Lerner Family Chiropractic Centre 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.

_____ Date: _____
Parent or Legal Guardian's Signature Date