

PEDIATRIC HISTORY FORM

PATIENT DEMOGRAPHICS

Child's Name _____ Date of Birth ____/____/____

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

Address _____

City _____ State _____ Zip _____

Guardian's Name: _____ Relationship: _____ Guardian's Phone#: _____

Guardian's Name: _____ Relationship: _____ Guardian's Phone#: _____

Pediatrician/Family MD: _____ City & State: _____

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

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

☐ Other (please explain): _____

CHILD'S CURRENT PROBLEM:

Purpose of visit: ____ Principled Chiropractic ____ Wellness Check-up ____ Injury/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 ____/____/____
____ Gradual ____ Sudden

2. How long has this problem lasted?
____ Days ____ Weeks ____ Months ____ Years

3. Ever had this problem before? ____ No ____ Yes; If yes when? _____

4. What were the results of past treatment? _____

5. How is this problem NOW:

____ Rapidly Improving ____ Slowly Improving ____ About the Same
____ Gradually Worsening ____ On & Off

6. Please list any medication taken for this problem: _____

7. Has your child ever sustained an injury in an auto accident? ____ No ____ Yes

If yes; please explain: _____

Symptoms and Dysfunctions

(Check all the apply)

- | | |
|--|--|
| <input type="checkbox"/> Neck Problems | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Upper Back Pain | <input type="checkbox"/> Ear Infections |
| <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Allergies / Sinuses |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Cold / Flu |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Arm Problems | <input type="checkbox"/> Digestive Issues |
| <input type="checkbox"/> Leg Problems | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Hip Problems | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Muscle / Growing Pain | <input type="checkbox"/> Heart Problems |
| <input type="checkbox"/> Joint Problems | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Poor Posture | |

- | | |
|---|--|
| <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Motor Milestone Delays |
| <input type="checkbox"/> Torticollis (downward tilt of head) | <input type="checkbox"/> Speech / Communication Delays |
| <input type="checkbox"/> Colic / Excessive Crying | <input type="checkbox"/> Sensory Processing Challenges |
| <input type="checkbox"/> Difficulty Latching / Nursing | <input type="checkbox"/> Social / Emotional Challenges |
| <input type="checkbox"/> Reflux / Excessive Spit Up | <input type="checkbox"/> Behavioral Issues / Frequent Tantrums |
| <input type="checkbox"/> Projectile Vomiting | <input type="checkbox"/> Hyperactivity / Impulsivity |
| <input type="checkbox"/> Frequent Stiffening / Rigidity / Arching | <input type="checkbox"/> Anxiety / Emotional Instability |
| <input type="checkbox"/> Difficulty Sleeping | <input type="checkbox"/> ADD / ADHD |
| | <input type="checkbox"/> Balance Issues |

ACTIVITIES OF DAILY LIVING

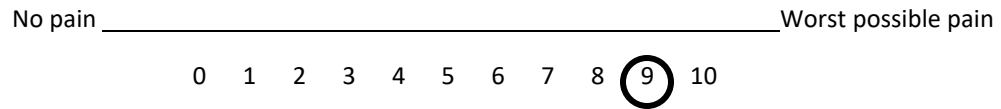
Please identify how the current condition is affecting their ability to carry out activities that are routinely part of their life:

- | | |
|---|---|
| <input type="checkbox"/> Walking | <input type="checkbox"/> Concentrating |
| <input type="checkbox"/> Do Static Sitting | <input type="checkbox"/> Socially Interact with Others |
| <input type="checkbox"/> Do Static Standing | <input type="checkbox"/> Climbing Stairs |
| <input type="checkbox"/> Sleeping | <input type="checkbox"/> Using the Bathroom (Bowel/Urine) |
| <input type="checkbox"/> Sitting Cross-Legged | <input type="checkbox"/> Feeding/Retaining Meals |
| <input type="checkbox"/> Turning Head Left to Right | <input type="checkbox"/> Playing |

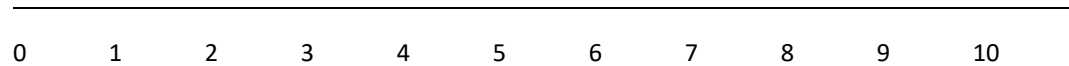
QUADRUPLE VISUAL ANALOGUE SCALE (QVAS)

Please **circle** the number that best describes the question asked. If you have more than one complaint, please answer each question for each individual complaint and indicate the score of each complaint.

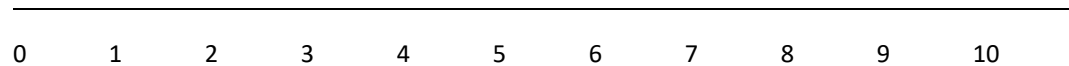
EXAMPLE:



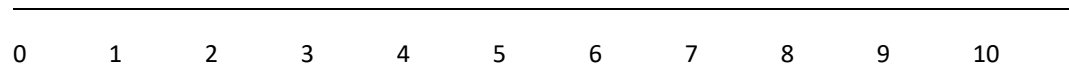
1. How would you rate your pain RIGHT NOW?



2. What is your typical or AVERAGE pain?

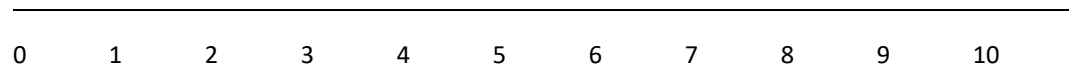


3. What is your pain level at its BEST? (How close to 0 does your pain get at its best?)



What percentage of your awake hours is your pain at its best? _____%

4. What is your pain level at its WORST? (How close to 10 does your pain get at its worst?)



What percentage of your awake hours is your pain at its worst? _____%

Practice Member Name: _____ Date: _____

Score: Q1____+Q2____+Q4____=____/3x10=____ (Low Intensity = <50; High Intensity = >50)

Terms of Acceptance

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

Legal Guardian's Signature

Date

Doctor or CA's Signature

Date

Notice of Privacy Practices Acknowledgement

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I understand that this information can and will be used to:

1. Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physician's certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclose to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

Name of Child or Minor

Date

Legal Guardian's Signature

Date