maxliving HEALTH CENTER Greenway Health Center

PEDIATRIC HISTORY FORM

PATIENT DEMOGRAPHICS

HR#:_____

Childs Name_____Today's Date_____/_____/_____

Date of Birth_____/_____/_____ Birth Height:_____Birth Weight:_____Current Height: _____

Current Weight:_____ Age:____ Address _____ City_____

State_____Zip_____Phone (Home) _____ Mother's Name:_____

Mother's Mobile_____DOB __/_____/____

Fathers name:_____Father's Mobile_____DOB____/____/____

Pediatrician/Family MD_____City & State _____

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

Who is responsible for this bill? _____

☐ Father's Social Security #_____-_____-_____ ☐ Mother's 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?: (◯Y/◯N) If 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

_____

HAS YOUR CHILD EVER SUFFERED FROM: mark **Y** for YES or **N** for NO

Headaches
Dizziness
Fainting
Seizures/Convulsions
Heart Trouble
Chronic Earaches
Sinus Trouble
Scoliosis
Bed Wetting
Fall in baby walker
Fall off bicycle
Fall from changing table

Orthopedic Problems
Neck Problems
Arm Problems
Leg Problems
Joint Problems
Backaches
Poor Posture
Anemia
Colic
Fall from bed or couch
Fall from high chair
Fall off monkey bars

Digestive Disorders
Poor Appetite
Stomach Ache
Reflux
Constipation
Diarrhea
Hypertension
Colds/Flu
Broken Bones
Fall from crib
Fall off slide
Fall off skateboard/skates

Behavioral Problems
ADD/ADHD
Ruptures/Hernia
Muscle Pain
Growing Pains
Allergies to_____
Asthma
Walking Trouble
Sleeping Problems
Fall off swing
Fall down stairs
Other: _____

I understand that I am directly and fully responsible to this office for all fees associated with chiropractic care my child receives.

The risks associated with exposure to x-rays 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. I hereby request and authorize this office to administer healthcare as deemed necessary to my dependent minor child. This authorization also extends to include diagnostic imaging, laboratory and other testing at the doctor's discretion.

☐ 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 _____

Doctor Signature _____ Date _____

INFORMED CONSENT

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at _____ Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ ____/____/____ Witness Initials

Patient or Authorized person's Signature Date

REGARDING: X-rays/Imaging Studies

FEMALES ONLY: please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.

☐ The first day of my last menstrual cycle was on____/____/____ Date

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____ ____/____/____ Witness Initials

Patient or Authorized person's Signature Date