Thiele Chiropractic & Wellness

File #: _____
Date: _____/_____/_____

PEDIATRIC HISTORY FORM

Patient Information

First Name: _____ MI: _____ Last Name: _____ Today's Date: _____/_____/_____
Date of Birth: _____/_____/_____ Current Height: _____ Current Weight: _____
Address: _____ City: _____ State: _____ Zip: _____
Primary Phone: ( ) _____ Secondary/Mobile Phone: ( ) _____
Mother: _____ Date of Birth: _____/_____/_____
Father: _____ Date of Birth: _____/_____/_____
Pediatrician/Family MD: _____ City & State: _____ Last Visit: _____/_____/_____
Who is responsible for payments to this office for services rendered?
☐Father SSN: _____ -_____-_____ ☐Mother SSN: _____ -_____-_____
☐Other (please explain): _____

Patient Condition

Reason(s) for visit: ☐Wellness Check-up ☐Injury or Accident ☐Other: _____
_____

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? _____
   How long ago? _____ Days _____ Weeks _____ Months _____ Years
   What were the results of past treatment? _____
5. How is this problem now?
   ☐Rapidly improving ☐Improving slowly ☐About the same ☐Gradually Worsening ☐On & Off
6. Please list any medication(s) taken for this problem: _____
7. Has your child ever sustained an injury playing organized sports? ☐No ☐Yes If yes, please explain: _____
   _____
   _____
8. Has your child ever sustained an injury in an auto accident? ☐No ☐Yes If yes, please explain: _____
   _____
   _____
9. Any other significant injuries or surgeries? ? ☐No ☐Yes If yes, please explain: _____
   _____
   _____

Allergies

Are you allergic to any medication(s)? ☐Yes ☐No If yes, list medications: _____
_____
Other known allergies:
☐Latex ☐Shellfish ☐Peanuts ☐Dairy Other: _____
Reaction(s): _____

Immunizations

☐All recommended vaccines	☐Influenza	☐Tetanus
☐Adenovirus	☐IPV (polio)	☐Varivax (chicken pox)
☐DTaP (diphtheria, tetanus, pertussis)	☐MMR (measles, mumps, rubella)	☐Other: _____
☐Haemophilus B	☐Pneumonia	☐Not vaccinated
☐Hepatitis B	☐Rotavirus	

Personal Health History

☐Headaches	☐Orthopedic problems	☐Digestive disorders	☐Behavioral problems
☐Dizziness	☐Neck problems	☐Poor appetite	☐ADD/ADHD
☐Fainting	☐Arm problems	☐Stomach aches	☐Ruptures/Hernia
☐Seizures	☐Leg problems	☐Reflux	☐Muscle pain
☐Heart trouble	☐Joint problems	☐Constipation	☐Growing pains
☐Chronic earaches	☐Backaches	☐Diarrhea	☐Asthma
☐Sinus trouble	☐Poor posture	☐Hypertension	☐Walking trouble
☐Scoliosis	☐Anemia	☐Colds/Flu	☐Sleeping problems
☐Bed wetting	☐Colic	☐Broken bones	

☐Fall(s) Please specify: _____

☐Other: _____

I understand that I am directly and fully responsible to Thiele Chiropractic & Wellness 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 my doctor. After careful consideration I do hereby request, and authorize imaging studies (only if necessary), and chiropractic adjustments, for the benefit of my minor child, for whom I have legal right to select, and authorize health care services on behalf of.

Under 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.

Patient or Legal Guardian's Signature Relationship to patient Date

Doctor's Signature Date Reviewed