RESTORE FAMILY
CHIROPRACTIC

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?: (___Yes ___ No). 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: (Please check all that apply)

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

Type name in lieu of signature.

Doctor Name _____ Date _____

Activities of Daily Living/Symptoms/Medications

Patient Name: _____ Date: _____ HRN:_____

Daily Activities: Effects of Current conditions On Performance

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

Bending	___No Effect	___Painful (can do)	___Painful (limits)	___Unable to Perform
Concentrating	___No Effect	___Painful (can do)	___Painful (limits)	___Unable to Perform
Doing computer Work	___No Effect	___Painful (can do)	___Painful (limits)	___Unable to Perform
Gardening	___No Effect	___Painful (can do)	___Painful (limits)	___Unable to Perform
Playing Sports	___No Effect	___Painful (can do)	___Painful (limits)	___Unable to Perform
Recreation Activities	___No Effect	___Painful (can do)	___Painful (limits)	___Unable to Perform
Shoveling	___No Effect	___Painful (can do)	___Painful (limits)	___Unable to Perform
Sleeping	___No Effect	___Painful (can do)	___Painful (limits)	___Unable to Perform
Watching TV	___No Effect	___Painful (can do)	___Painful (limits)	___Unable to Perform
Carrying	___No Effect	___Painful (can do)	___Painful (limits)	___Unable to Perform
Dancing	___No Effect	___Painful (can do)	___Painful (limits)	___Unable to Perform
Dressing	___No Effect	___Painful (can do)	___Painful (limits)	___Unable to Perform
Lifting	___No Effect	___Painful (can do)	___Painful (limits)	___Unable to Perform
Pushing	___No Effect	___Painful (can do)	___Painful (limits)	___Unable to Perform
Rolling Over	___No Effect	___Painful (can do)	___Painful (limits)	___Unable to Perform
Sitting	___No Effect	___Painful (can do)	___Painful (limits)	___Unable to Perform
Standing	___No Effect	___Painful (can do)	___Painful (limits)	___Unable to Perform
Working	___No Effect	___Painful (can do)	___Painful (limits)	___Unable to Perform
Climbing	___No Effect	___Painful (can do)	___Painful (limits)	___Unable to Perform
Doing Chores	___No Effect	___Painful (can do)	___Painful (limits)	___Unable to Perform
Driving	___No Effect	___Painful (can do)	___Painful (limits)	___Unable to Perform
Performing Sexual Activity	___No Effect	___Painful (can do)	___Painful (limits)	___Unable to Perform
Reading	___No Effect	___Painful (can do)	___Painful (limits)	___Unable to Perform
Running	___No Effect	___Painful (can do)	___Painful (limits)	___Unable to Perform
Sitting to Standing	___No Effect	___Painful (can do)	___Painful (limits)	___Unable to Perform
Walking	___No Effect	___Painful (can do)	___Painful (limits)	___Unable to Perform

Please mark P for in the Past, C for Currently have and N for Never

____ Headache	____ Pregnant (Now)	____ Dizziness	____ Prostate Problems	____ Heartburn
____ Neck Pain	____ Frequent Colds/Flu	____ Loss of Balance	____ Digestive Problems	____ Digestive Problems
____ Jaw Pain, TMJ	____ Convulsions/Epilepsy	____ Fainting	____ Colon Trouble	____ High Blood Pressure
____ Shoulder Pain	____ Tremors	____ Double Vision	____ Diarrhea/Constipation	____ Low Blood Pressure
____ Upper Back Pain	____ Chest Pain	____ Blurred Vision	____ Menopausal Problems	____ Asthma
____ Mid Back Pain	____ Pain w/Cough/Sneeze	____ Ringing in Ears	____ Menstrual Problem	____ Difficulty Breathing
____ Low Back Pain	____ Foot or Knee Problems	____ Hearing Loss	____ PMS	____ Lung Problems
____ Hip Pain	____ Sinus/Drainage Problem	____ Depression	____ Bed Wetting	____ Kidney Trouble
____ Back Curvature	____ Swollen/Painful Joints	____ Irritable	____ Learning Disability	____ Gall Bladder Trouble
____ Scoliosis	____ Skin Problems	____ Mood Changes	____ Eating Disorder	____ Liver Trouble
____ Numb/Tingling arms, hands, fingers		____ ADD/ADHD	____ Trouble Sleeping	____ Hepatitis (A, B, C)
____ Allergies		____ Ulcers		

List Prescription & Non-Prescription drugs you take:

_____

_____

_____

_____

How did you hear about us?

_____

_____

FOR OFFICE USE ONLY
I have reviewed the above ADL & ROS Form with the above-named patient:

_____ _____
Doctor Signature Date