APPLICATION FOR CARE AT PEACOCK FAMILY CHIROPRACITC

Whom may we thank for connecting you to our office? ____

PEDIATRIC HISTORY FORM

PATIENT DEMOGRAPHICS **FOR OFFICE USE:** HR#:________________

Childs Name____ Today's Date ____/____/____ Date of Birth ____/____/_____

Birth Height: ______ Birth Weight: _______ Current Height: _______Current Weight: _______ Age: ______ ☐ Male ☐ Female

Address: ____ Email:____

City :____________________ State: ______ Zip: ________________ Phone (Home): ____________________

Mothers Name: _____________________________________Mother's Mobile: __________________________DOB___/___/_____

Fathers name: _____________________________________Father's Mobile: ___________________________DOB ___/___/_____

Other Parent/Guardian: _____________________ Relation to Child: ___________ Mobile: ________________DOB ___/___/_____

Pediatrician/Family MD: _______________________________City & State: ______________________

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

Who is responsible for this bill? ____ Do you have Insurance: ☐ Yes ☐ No

☐ Father's Social Security # _____-_____-______☐ Mother's Social Security # ______-_____-______

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?: If yes, *(Describe)*:____
4. Have you seen any **other doctors** for this problem? No Yes If yes who? ____________________________

   If yes, 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 taken** for this problem: ____
7. Has your child ever sustained an injury playing organized sports? ______ If yes; please explain

   ____

   ____

8. Has your child ever sustained an injury in an auto accident? _____ if yes, please explain

   ____

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HAS YOUR CHILD SUFFERED FROM: *please mark P for in the Past, C for Current, and N for Never*

___ Headaches	___ Orthopedic Problems	___ Digestive Disorders	___ Behavioral Problems
___ Dizziness	___ Neck Problems	___ Poor Appetite	___ ADD/ADHD
___ Fainting	___ Arm Problems	___ Stomach Aches	___ 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: ___________________

LIST ANY RESTRICTED ACTIVITIES:	CURRENT ACTIVITY LEVEL	USUAL ACTIVITY LEVEL
______________________:	______________________	______________________
______________________:	______________________	______________________
______________________:	______________________	______________________

List any Prescription & Non-Prescription medication your child takes: ____

____

List any vitamins your child takes: ____

____

I understand that I am directly and fully responsible to Peacock Family 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 marital status, divorce, separation or other legal authorization, the consent of my spouse/former spouse or other guardian is not required. If my authority to 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

KP 1/2014