

3520 Snouffer Rd, Suite 202 Columbus, OH 43235 P: (567)-230-4156

PEDIATRIC HISTORY

Today'sDa	ite / /	
ChildsNan	ne	
Dateof Bir	rth / / Age:	
BirthHeigl	ht: BirthWeight: Curre	ntHeight: CurrentWeight:
Address_		
City	StateZip	Phone(Home)
Mother'sN	ame:DOB /	Mother's Mobile
Father'sNa	nme:DOB/_	/ Father'sMobile
Pediatricia	ın/FamilyMD	City/State
BEGINNI	NG OF LIFE: there any fertility or pregnancychallenges	
	here any intervention at birth includingind	
	there any problems in the firstyear?	
O	Colic	• Sleepingissues
0	Breastfeeding/ latchingissues	O Poopingissues
0	Tongue-tie	• Recurrent earinfections
0	Reflux	 Multiple rounds ofantibiotics
0	Allergies	
0	Other	

CHILD'S CURRENT PROBLEM: Purpose of thisvisit: WellnessCheck-up Injury or Accident Other Please explain:							
_ [f	f your child is experiencing Pain/Discomfort? Please identify where and for how long.						
١.	WhendidtheProblemfirstbegin?Date_/_/Unknown Gradual Sudden						
2.	Everhadthisproblembefore?_No_Yeslfyes,when?						
3.	Any bowel or bladder problems since this problem began?: If yes, describe:						
ــ ١.	Haveyouseenany otherdoctors forthisproblem?_No _Yes If yes,who?						
	Howlongago? Days Weeks Months Years Whatweretheresultsofpasttreatment?						
	How is thisproblemNOW?: DRapidlyImproving DImprovingSlowly D About theSame GraduallyWorsening □On &Off						
3.	Pleaselistany medicationtaken forthisproblem:						
).	Hasyourchildeversustainedaninjuryplayingorganizedsports?_No_YesIfyes;please explain:						
10.	Has your child ever sustained an injury in an autoaccident?_No _ Yes If yes; pleaseexplain:						

HAS YOUR CHILD EV	ER SUFFERED FROM: C	heck all that apply			
☐ Headaches	□Orthopedic Problems	□Digestive Disorders [∃Behavioral Problems		
□Dizziness □Neck Pro	blems □Poor Appetite □A	.DD/ADHD			
□Fainting □Arm Proble	ems 🗆	Stomach Aches	□Ruptures/Hernia		
□Seizures/Convulsions	□Leg Problems □Reflux [⊐Muscle Pain			
☐ Heart Trouble ☐ ☐Joint Problems ☐Constipation ☐Growing Pains					
□Chronic Earaches □B	ackaches □Diarrhea □Ast	hma			
□Sinus Trouble □Poor	Posture □Hypertension □]	Walking Trouble		
□Scoliosis □Anemia □	lColds/Flu □Sleeping Prob	lems			
☐ Bed Wetting	□ Colic	☐ Broken Bones	\square Fall off swing		
□Fall in baby walker	\square Fall from bed or couc	h□Fall from crib□Fal	l down stairs		
□Fall off bicycle □Fall f	from high chair □Fall off sl	ide			
☐ Fall from changing tak	ole □ Fall off monkey bars	☐ Fall off skateboard/s	skates		
☐ Allergies to					
<u> </u>					
with chiropractic care my The risks associated with my complete satisfactio careful consideration I of for the benefit of my my services on behalf of. Under the terms and of a spouse/former spou	h exposure to ionization ann, and I have conveyed my lo hereby request and auth inor child for whom I have conditions of my divorce, s	nd spinal adjustments hat understanding of these orize imaging studies and the legal right to select separation or other legal required. If my authority	we been explained to me to e risks to the doctor. After d chiropractic adjustments and authorize health care authorization, the consent y to so select and authorize		
Parent or Legal Guardian	n's Signature	 Date			
Doctor's Signature		Date			