PEDIATRIC HISTORY FORM

(cont.)Patient's Name:_____

CHILD'S PAST HISTORY:

1. History of injuries/accidents: _____

_____

_____

2. Any complications at Birth?:_____

_____

3. Has your child been immunized recently?_____No_____Yes (please explain):_____

_____

_____

4. Has your child had any childhood diseases?:_____

_____

HAS YOUR CHELD EVER SUFFERED FROM: *(Check all that apply):*

__Headaches	__Orthopedic problems	__Digestive Problems	__Behavioral problems
__Dizziness	__Neck Problems	__Poor Appetite	__ADD/ADHD
__Fainting	__Arm Problems	__Stomach aches	__Ruptures/hernias
__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	__Falling off swing
__Falling from bed/couch		__Fall from bike	__Fall off slide

__Fall downstairs __any other falls:_____

I understand THAT I AM DIRECTLY AND FULLY RESPONSIBLE TO Dr. Meshew for all fees associated with Chiropractic care my child receives.

The risks associated with exposure to spinal adjustments have been explained to me to my complete satisfaction, & I have conveyed my understanding of these risks to the doctor. After careful consideration I do hereby request & authorize imaging studies (if necessary) & Chiropractic adjustments for the benefit of my minor child for whom I have the legal right to select and authorize health care services on the behalf of.

___Under the terms & 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 & authorize this care should change in any way, I will immediately notify this office.

_____/_____ _____

(Parent/legal guardian)PRINT/SIGNATURE (Date)

_____/_____ _____

(witness) PRINT/SIGNATURE (Date)

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