PEDIATRIC HISTORY FORM

PATIENT DEMOGRAPHICS

Today's Date:___/___/____ Child's Name:_____
(print)

Date of Birth:__/__/____ Age:_____

Birth Height:_____" Birth Weight:_____lbs.

Current Height:_____" Current Weight:_____lbs.

Address: Same or (If different then parents):_____

City:_____State:_____ Zipcode:_____

Mother's full name:_____Phone:_____

Father's full name:_____Phone:_____

Pediatrician/Family MD:_____City/State:_____/_____

Last visit:_____Reason for visit:_____

_____

Who is responsible for this bill?_____

(relationship to child):_____

___Father

___Mother

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 & for how long:***_____

_____

_____

1. When did the problem first begin (date):___/____/_____ __Unknown ___Gradual___Sudden
2. Ever had this problem before?___No ___Yes (If yes, please explain)_____

_____

3. Any bowel or bladder problems since this problem began?_____
4. Have you seen any other doctors (including Chiropractors/Acupuncturists)?_____

_____

5. Please list any medications taken currently & for what reason:_____

_____

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