PEDIATRIC HISTORY FORM FOR TANZAR CHIROPRACTIC

PATIENT DEMOGRAPHICS

File#:__________________

Childs Name____ Today's Date ____/____/___

Date of Birth ____/____/_____ Birth Height: ______ Birth Weight: ______ Current Height: _____

Current Weight: ____ Age: ____ Address ____

City _________________ State ______ Zip ______________ Phone (Home) _________________

Mothers 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?: 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: mark **Y for** YES OR **N for** NO

☐ 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: ___________________

I understand that I am directly and fully responsible to Tanzar 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 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*

Doctor Signature ______________________ *Date*_______________

JDD,DC 5/2011

Activities of Daily Living/Symptoms/Medications

Patient Name: ____________________________________ File#_____________ **Date:** _________________

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:

Activity				
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

Patient Name____ File#_____________ Date__________

INITIAL NERVE SYSTEM PROFILE

When was your most recent auto accident? ____

What speed was the collision? ____

Type of impact: Front Impact / Side Impact / Rear Impact

Was treatment received? Please describe ____________________________________

When was your most recent strain / stress at work? ____________________________________

Please describe the manner of the injury ______________________________________

Was treatment received? Please describe ____________________________________

Does your job require you remain in long term stressful postures?___________________

(*i.e. all day seating, repeated lifting, long term computer use)*

Spinal traumas in the past? ____

Collision, quick burst, or repetitive motion sports: football, wrestling, basketball, baseball, soccer, tennis, golf, track and field____

Trauma as a child! i.e. fall on your head, impact to your head, concussion, fall onto your back or tailbone, biking accident____

Work around the house – lifting, bending, woke up with stiff neck, "back went out"

Doctor Signature ___________________________________ Date____________________

JDD, DC 5/2011