

PEDIATRIC HISTORY FORM

Thrive Integrated Health | 4115 N Steele Blvd | Fayetteville, AR 72703 | (479) 439-8121

PATIENT DEMOGRAPHICS

Child's Name: _____ Today's Date ____/____/____
Date of Birth: ____/____/____ Birth Height: _____ Birth Weight: _____
Current Height: _____ Current Weight: _____ Address _____
City _____ State _____ Zip _____ Phone (Home) _____
Age: _____ City: _____ State: _____
Mother's Name: _____ Father's Name: _____
Pediatrician / Family MD: _____
City / State: _____ Last Visit: ____/____/____
Reason for visit: _____
Who is responsible for this bill? _____
Father's Social Security #: _____ - _____ - _____ Mother's Social Security #: _____ - _____ - _____
Email: _____ Health Insurance: Yes or No

CHILD'S CURRENT PROBLEM:

Purpose of this visit: ____ Wellness Check-up ____ Injury or Accident ____ Other: _____

*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? _____
How long ago? _____ Days _____ Weeks _____ Months _____ Years
5. What were the results of past treatment? _____
6. How is this problem **NOW**: Rapidly Improving Improving Slowly About the Same
 Gradually Worsening On & Off
7. Please list any **medication taken** for this problem: _____
8. Has your child ever sustained an injury playing organized sports? _____ If yes; please explain _____
9. Has your child ever sustained an injury in an auto accident? _____ if yes, please explain _____

PREGNANCY HISTORY:

Third Trimester Presentation: _____ Vertex _____ Breech _____ Transverse _____ Face/Brow

Type of Birth: _____ Normal Vaginal _____ Forceps _____ Cesarean _____ Suction Cap or Vacuum

Location: _____ Home _____ Hospital _____ Birthing Center _____ Other: _____

Problems during Pregnancy: _____

Problems during Labor/Delivery: _____

Was there presence of: _____ Jaundice? (Yellow) _____ Cyanosis? (Blue) _____ Congenital Anomalies/Defects?

If yes, please explain _____

INFANT HISTORY:

Infant feeding: _____ Breast _____ Bottle If Bottle, which Formula? _____

Number of Hours Sleep Per Night _____ Quality of Sleep: _____ Good _____ Fair _____ Poor

List all **IMMUNIZATIONS** you child has had _____

Has your child ever been treated at the emergency room? _____ If yes, please explain _____

Has your child ever been hospitalized? _____ If yes, please explain _____

Has your child ever had any surgeries? _____ If yes, please explain _____

Is your child currently on any medication? _____ If yes, please list _____

AT WHAT AGE DID THE CHILD:

_____ Respond to Sound _____ Follow an Object with his/her eyes _____ Hold Heel Up

_____ Sit Alone _____ Crawl _____ Stand _____ Walk Alone

AT WHAT AGE, IF EVER, DID CHILD SUFFER FROM THE FOLLOWING:

_____ Chicken Pox _____ Mumps _____ Measles _____ Rubella

_____ Whooping Cough _____ Other: _____

HAS YOUR CHILD EVER SUFFERED THE FOLLOWING SPINAL TRAUMAS:

- Fall in baby walker Fall from bed or couch Fall off skateboard or skates 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 Other: _____

Has your child ever sustained an injury playing organized sports? _____ If yes, please explain _____

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

HAS YOUR CHILD EVER SUFFERED FROM: Please *checkmark (✓)* for **YES** or leave **blank** for **NO**

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Orthopedic Problems | <input type="checkbox"/> Digestive Disorders | <input type="checkbox"/> Behavioral Problems |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Neck Problems | <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> ADD/ADHD |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Arm Problems | <input type="checkbox"/> Stomach Aches | <input type="checkbox"/> Ruptures/Hernia |
| <input type="checkbox"/> Seizures/Convulsions | <input type="checkbox"/> Leg Problems | <input type="checkbox"/> Reflux | <input type="checkbox"/> Muscle Pain |
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Joint Problems | <input type="checkbox"/> Constipation | <input type="checkbox"/> Growing Pains |
| <input type="checkbox"/> Chronic Earaches | <input type="checkbox"/> Backaches | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Allergies to _____ |
| <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Poor Posture | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Anemia | <input type="checkbox"/> Colds/Flu | <input type="checkbox"/> Walking Trouble |
| <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Colic | <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Sleeping Problems |
| <input type="checkbox"/> Fall in baby walker | <input type="checkbox"/> Fall from bed or couch | <input type="checkbox"/> Fall from crib | <input type="checkbox"/> Fall off swing |
| <input type="checkbox"/> Fall off bicycle | <input type="checkbox"/> Fall from high chair | <input type="checkbox"/> Fall off slide | <input type="checkbox"/> Fall down stairs |
| <input type="checkbox"/> Fall from changing table | <input type="checkbox"/> Fall off monkey bars | <input type="checkbox"/> Fall off skateboard/skates | <input type="checkbox"/> Other: _____ |

FAMILY HISTORY:

Please indicate if your child or a family member has had any of the following: Write "C" for child, "F" for family member:

- | | | |
|-------------------------------|------------------------------|----------------------|
| ____ Heart Disease | ____ Diabetes | ____ Stroke |
| ____ Cancer | ____ High/Low Blood Pressure | ____ Asthma |
| ____ Gastrointestinal Disease | ____ Memory/Mood Disorder | ____ Thyroid Problem |

I understand that I am directly and fully responsible to [Thrive Integrated Health](#) 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's Signature

Date