Whom may we thank for referring you to this office → ______________________________________?

PEDIATRIC HISTORY FORM

Thrive Wellness Center | 4155 N Steele Blvd #10 | 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***

☐ 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: _________________

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 Wellness Center 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