ATLAS CHIROPRACTIC
MONTROSE

PEDIATRIC HISTORY FORM

PATIENT DEMOGRAPHICS **Today's Date ____/____/____** **PMID:_____**

Name: _____ Birth Date: _____-_____-_____ Age: _____ ☐ Male ☐ Female

Birth Height: _____ Birth Weight: _____ Current Height: _____ Current Weight: _____

Address _____City _____ State _____ Zip _____

Phone (Home) _____ Family E-mail_____

Mother's Name: _____ DOB____/____/____ Mother's Mobile _____

Father's Name: _____DOB ____/____/____ Father's Mobile _____

Pediatrician/Family MD _____City/State _____

Last Visit: ____/____/____ Reason for visit:_____

Who is responsible for costs associated with chiropractic care? _____

☐ Father's Social Security #_____-_____-_____ ☐ Mother's Social Security #_____-_____-_____

☐ Other *(please explain)*: _____

REASON FOR PURSUING CARE:

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***

_____

_____

When did the Problem first begin? Date ___/___/___ __Unknown __Gradual __Sudden

Ever had this problem **before**? ___ No ___Yes If yes, when? _____

Any **bowel or bladder** problems since this problem began?: If yes, describe:_____

_____

Have you seen any **other doctors** for this problem? ___No ___Yes If yes, who?

_____

How long ago? _____Days _____Weeks _____Months _____Years

What were the results of past treatment? _____

How is this problem **NOW?:** ☐ Rapidly Improving ☐ Improving Slowly ☐ About the Same ☐ Gradually Worsening ☐ On & Off

Please list any **medication taken** for this problem: _____

1. Has your child ever sustained an injury playing organized sports? ___ No ___ Yes If yes; please explain:

_____

_____

2. Has your child ever sustained an injury in an auto accident? ___ No ___ Yes If yes; please explain:

_____

_____

BIRTH EXPERIENCE:

Your child's spine is very vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference).

Birth Height: _____ Birth Weight: _____ APGAR Scores: ___-___ Complications?:_____

Birth Intervention**:** ☐ Forceps ☐ Vacuum Extraction ☐ C-Section (Planned) ☐ C-Section (Emergency)

Breast Fed: ☐ Yes / ☐ No How long?_____ Formula Fed: ☐ Yes / ☐ No How long?_____ Vaccinated: ☐ Yes / ☐ No

At what age was your child able to:

_____ Respond to stimuli _____ Cross Crawl _____ Sit up _____ Stand alone
_____ Respond to visual stimuli _____ Hold head up _____ Walk alone

HAS YOUR CHILD EVER SUFFERED FROM: *Check all that apply*

☐ 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	☐ Asthma
☐ Sinus Trouble	☐ Poor Posture	☐ Hypertension	☐ Walking Trouble
☐ Scoliosis	☐ Anemia	☐ Colds/Flu	☐ Sleeping Problems
☐ Bed Wetting	☐ Colic	☐ Broken Bones	☐ Fall off swing
☐ Fall in baby walker	☐ Fall from bed or couch	☐ Fall from crib	☐ Fall down stairs
☐ Fall off bicycle	☐ Fall from high chair	☐ Fall off slide	☐ Other:_____
☐ Fall from changing table	☐ Fall off monkey bars	☐ Fall off skateboard/skates	

☐ Allergies to_____

Is there anything else you would like us to know about your child?

_____

What are your health goals for your child?

_____

QUADRUPLE VISUAL ANALOGUE SCALE

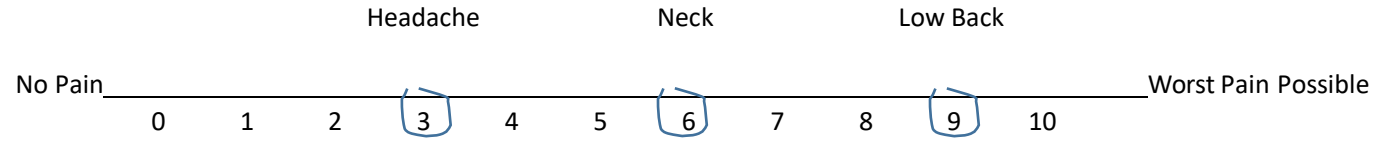
Patient Name_____ Date _____

Please read carefully:

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:



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1 – What is your pain RIGHT NOW?

No Pain_____**Worst Pain Possible**

0 1 2 3 4 5 6 7 8 9 10

2 – What is your TYPICAL or AVERAGE pain?

No Pain_____**Worst Pain Possible**

0 1 2 3 4 5 6 7 8 9 10

3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

No Pain_____**Worst Pain Possible**

0 1 2 3 4 5 6 7 8 9 10

4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No Pain_____**Worst Pain Possible**

1 2 3 4 5 6 7 8 9 10

OTHER COMMENTS:

_____

_____

Examiner

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