Date: _____

PEDIATRIC PATIENT HISTORY

Name_____ Pt. ID # _____ DOB ____/____/____ Age: _____

Address _____ City _____ State _____ Zip _____

Mother's Name _____ Phone _____ DOB: _____

Father's Name _____ Phone _____ DOB: _____

Check off any of the following symptoms your child has ever experienced:

☐ Chronic Ear Aches	☐ Allergies	☐ Neck Problems	☐ Headaches
☐ Asthma	☐ Convulsions	☐ Orthopedic Problems	☐ Joint Pains
☐ Lung Infections	☐ Blood Disorders	☐ Ankle/Foot/Leg Pain	☐ Behavioral Problems
☐ Frequent Colds/Flu	☐ Heart Problems	☐ Broken Bones	☐ Scoliosis
☐ Hyperactivity	☐ Weight Trouble	☐ Growing Pains	☐ _____
☐ Walking Problems	☐ Diabetes	☐ Backaches	☐ _____

Which of the above bothers your child the most? _____

How long have they been bothered by this condition? _____

Describe how it makes them feels when it is at its worst: _____

Medications:	**Childhood Illnesses:**	**Accidents / Injuries:**
☐ Prozac	☐ Arthritis/Inflammed Joints	☐ Difficult Birth
☐ Ritalin	☐ Osgood Schlatter's Disease	☐ Auto Accidents
☐ Antibiotics	☐ Legg Calves Perthe Disease	☐ Falls/Other Accidents
☐ Other	☐ Growth Plate Problems	☐ Sports Injuries

Pediatrician Information

Doctor _____

Address _____

Phone # _____ Fax _____

Early Detection & Correction

A good chiropractic exam can help detect early spinal problems in your children. Our goal is to help your family experience the best care possible. We gently treat the body, naturally, without drugs to remove the stress and imbalances causing problems in the body

Authorization of Care of Minor

I hereby authorize Amerihealth Chiropractic and Wellness and it's doctor's to administer care as they deem necessary to my child. I also realize that I am responsible for all fees charged by this office and I will pay for all services as they are performed.

Signed _____ Date _____ Witness _____