Infinity Wellness Center
Pediatric History Form

Name:_____ Today's Date: _____ Date of Birth: _____ HR# _____

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

Address: _____ City:_____ Zip Code: _____ Home Phone: _____

Mother's Name_____ Mother's Mobile Number _____ DOB_____

Father's Name _____ Father's Mobile Number _____ DOB_____

Pediatrician/Family MD _____ City/State _____

Last Visit to MD_____ Reason for MD visit _____

Who is financially responsible for this bill? _____

Father's SSN_____ Mother's SSN _____

Other (please explain) _____

Child's purpose of this visit: ❑Wellness Check-up ❑Injury or Accident ❑Other

(Please explain) _____

If your child is experiencing pain or discomfort, please identify where and duration: _____

_____

When did the problem first begin? Date _____ /_____ /_____ ❑Unknown ❑Gradual ❑Sudden

Has your child experienced this before? ❑Yes ❑No If yes, when? _____

Has your child experienced any **bowel or bladder** problems since this problem began? ❑Yes ❑No If yes, please describe:

_____

Have you seen any **other doctors** for this problem? ❑Yes ❑No If yes, whom?_____

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 ❑Sporadic

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

Has your child ever sustained an injury playing organized sports? ❑Yes ❑No If yes, please explain: _____

_____

Has your child ever sustained an injury in an auto accident? ❑Yes ❑No If yes, please explain: _____

_____

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Has your child ever suffered from…? Mark Y for Yes or N for No.

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

Other: _____

I understand that I am directly and fully responsible to Infinity 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 select and authorize this care should change in any way, I will immediately notify this office.

_____ _____

Parent or Legal Guardian's Signature Date Completed

_____ _____

Doctor's Signature Date Reviewed