TILTON CHIROPRACTIC & WELLNESS CENTER
PEDIATRIC HISTORY FORM (UNDER 18 YEARS OLD)

PATIENT DEMOGRAPHICS

Child's Name: _____ Today's Date _____

Birth Date: _____-_____-_____ Age: _____ ☐ Male ☐ Female Home Phone: _____

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

Address: _____ City: _____ State: _____ Zip: _____

Mother's Name: _____ Mother's Mobile: _____ DOB: _____-_____-_____

Father's Name: _____ Father's Mobile: _____ DOB: _____-_____-_____

Pediatrician/Family MD: _____ City & State: _____

Last Visit: _____-_____-_____ Reason for Visit: _____

Who is responsible for this bill: _____

CHILD'S CURRENT PROBLEM

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: _____

_____

1. When did the problem first begain? 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? ☐ No ☐ Yes If yes, please explain _____

   _____
4. Have you seen any other doctors for this problem? ☐ No ☐ Yes If yes, who? _____
5. How long ago? _____ Days _____ Weeks _____ Months _____ Years
6. What were the results of past treatments? _____
7. How is this problem NOW? ☐ Rapidly Improving ☐ Improving Slowly ☐ About the Same ☐ Gradually ☐ On & Off
8. Please list any medication taken for this problem: _____
9. Has your child ever sustained an injury playing organized sports? ☐ No ☐ Yes If yes, please explain _____

   _____

   _____
10. Has your child ever sustained an injury in an auto accident? ☐ No ☐ Yes If yes, please explain _____

    _____

    _____

HAS YOUR CHILD SUFFERED FROM...

Has your child suffered from: Mark Y for YES or N for NO

___ Headaches
___ Orthopedic Problems
___ Digestive Disorders
___ Behavioral Problems
___ Dizziness
___ Neck Problems
___ Poor Appetite
___ Add/ADHD
___ Fainting
___ Arm problems
___ Stomach Aches
___ Backaches
___ Allergies to: **(Please List)**

___ Diarrhea
___ Sinus Trouble
___ Poor Posture
___ Hypertension
___ Asthma
___ Scoliosis
___ Anemia
___ Colds/Flu
___ Walking Trouble
___ Bed Wetting
___ Colic
___ Broken Bones

___ Sleeping Problems
___ Poor Posture
___ Hypertension
___ Asthma
___ Scoliosis
___ Anemia
___ Colds/Flu
___ Walking Trouble
___ Bed Wetting
___ Colic
___ Broken Bones
___ Sleeping Problems

_____

_____

_____

_____

CONSENT TO TREAT A MINOR

By signing this, I give Dr. Tilton permission to treat my son/daughter as he sees fit for chiropractic care.

_____ _____

Patient Name (Please Print) Date of Birth

_____

Parent or Legal Guardian Name (Please Print)

_____ _____

Parent or Legal Guardian Signature Today's Date