Patient's Name: ______________________________ DOB: ______________

Today's Date: ___________________

Pediatric History Form

PATIENT DEMOGRAPHICS

Name: _______________________________ Birth Date: _____-_____-_____ Age: ______ Male/Female

Address: _____________________________ City: ______________________ Postal Code: __________

E-mail Address: _________________________

Mother's Name: ________________________ Phone: ____________________

Father's Name: _________________________ Phone: ____________________

Name of Family MD: _____________________ City: ______________________ Phone: ______________

Last Visit: ______________ Reason for last visit: ____

I give Vibrant Life Chiropractic permission to discuss my health history with the my family MD: YES / NO

HISTORY of COMPLAINT

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? ___________________________________
5. How long ago? ________Days ________ Weeks _________ Months ________Years
6. What were the results of past treatment? ____
7. How is this problem **NOW:** ▫ Rapidly Improving ▫ Improving Slowly ▫ About the Same ▫ Gradually Worsening ▫ On & Off
8. Please list any **medication taken** for this problem: ____
9. Has your child ever sustained an injury playing organized sports? _______ If yes; please explain

   ____

   ____
10. Has your child ever sustained an injury in an auto accident? _______ if yes, please explain

    ____

Dr. Adam Malick - Vibrant Life Chiropractic
21 Roysun Rd Unit 16, Woodbridge ON, L4L 8R3 (905) 266-0779

Patient's Name: ______________________________ DOB: ______________

HAS YOUR CHILD EVER SUFFERED FROM: *mark **N** for Now **P** for Past*

☐ 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 change table	☐ Fall off monkey bars	☐ Fall off skateboard/skates	

☐ Other: ______________________

____

Parent or Legal Guardian's Name

____ ____________________

Parent or Legal Guardian's Signature Date

____ ____________________

Doctor's Signature Date

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