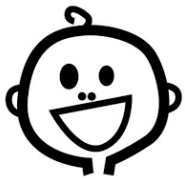
TREEHIVE
CHIROPRACTIC



PEDIATRIC FORM

Name_____ Date of Birth____/____/____ Age_____ Male/Female

Address_____City_____State_____ Zip_____

Guardian(s) Name:_____ Relationship:_____

Siblings: _____ Child's Social Security #: _____

Phone Number:_____ Weight: _____ Height: _____ Who may we thank for referring you?_____

List The Health Concerns That Brought You Into This Office

Health Concern: List according to severity.	Rate of Severity 0 = no pain 10 = unbearable	When did this problem start?	Have you had the problem before? If so, when?	Did the problem begin with an injury?	Are symptoms constant (C) or intermittent (I)?
Primary:					
Second:					
Third:					
Fourth:					

Have you ever seen other doctors for these conditions? □ Yes □ No

If Yes: □ Chiropractor □ Medical doctor □ Other_____

Who?_____ When?_____ Results?_____

_____

Please Mark "**P**" For In The **Past** OR Mark "**C**" For **Currently** Have:

___ Headaches	___ Ear Infections	___ Sinus Issues	___ Kidney Problems	___ Migraines
___ Hearing Loss	___ Frequent Colds	___ Bladder Problems	___ Sleep Problems	___Diabetes
___ Jaw/TMJ Pain	___ Ringing in the Ears	___ Thyroid Issues	___Seizures	___ Tight/Sore Muscles
___ Neck Pain	___ Dizziness	___ Asthma	___Scoliosis	___ Sports Injury
___ Shoulder Pain	___ Loss of Energy	___ Chest Pain	___ Infertility	___ Sciatica
___ Arm Pain	___ Nervousness	___ Heart Problems	___ Fibromyalgia	___ Joint Pain
___ Upper Back Pain	___ Double/Blurry Vision	___ Nausea	___ Epilepsy/Convulsions	___ GERD/Gastric Reflux
___ Mid Back Pain	___ Anxiety	___ Ulcers	___ Tremors	___ Numb/Tingling in Arms/Hands
___ Lower Back Pain	___ ADD/ADHD	___ Digestive Issues	___ Disc Problems	___ Numb/Tingling in Legs/Feet
___ Hip/Leg Pain	___ Loss of Balance	___ Diarrhea	___ Scoliosis	___ Stomach Problems
___ Knee Pain	___ Depression	___ Constipation	___ Poor Posture	___ Growing pains
___ Foot Pain	___ Allergies	___ Bed Wetting	___ Skin Problems	___ Difficulty Breathing

Other:_____

PREGNANCY INFORMATION:

How was your pregnancy?_____

Any pregnancy complications?_____

Did you take any medication during your pregnancy?_____

Other information: _____

Delivery Information:

Location of Birth: (Circle One) Hospital Birth Center Home

Birth Intervention: (Circle One) Forceps Vacuum Extraction Caesarian Section

_____

Induced? Yes/No Explain:

_____

Medications during delivery?_____

Other information: _____

Post Birth Information:

Birth Weight:_____ Birth Length: _____

Breast Fed: Yes/No How long?_____ Formula Fed Yes/No How Long?_____

Introduced Solid Foods at _____ Months

Food Allergies or intolerances:_____

Doses of antibiotics/prescription drugs your child has taken: Past 6 months_____ Total lifetime _____

Present prescription drugs/ dosage?_____

Over the counter drugs (Tylenol, cough syrup, laxatives, etc.)

_____

List all surgical operations & years: _____

Has your child ever been knocked unconscious? □ Yes □ No Fractured A Bone? □ Yes □ No

If yes to either of the above, please describe:_____

TREEHIVE
CHIROPRACTIC

Quadruple Visual Analogue Scale

Please circle the number that best describes the question asked. If you have more than one complaint, please answer each question for each individual complaint and indicate the score of each complaint.

EXAMPLE: No pain _____ Worst possible pain

0 1 2 3 (4) 5 6 7 (8) 9 10

1. How would you rate your pain RIGHT NOW?

0 1 2 3 4 5 6 7 8 9 10

2. What is your typical or AVERAGE pain?

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?)

0 1 2 3 4 5 6 7 8 9 10

What percentage of you're awake hours is your pain at its best? _____%

4. What is your pain level at its WORST? (How close to 10 does your pain get at its worst?)

0 1 2 3 4 5 6 7 8 9 10

What percentage of your awake hours is your pain at its worst? _____%

Activities Of Life

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITY:	EFFECT:			
Holding Head Up	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Tummy Time	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Nursing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sitting Up	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Crawling	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Standing Alone	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Walking Alone	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Other: _____	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Other: _____	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform

LIST RESTRICTED ACTIVITY	CURRENT ACTIVITY LEVEL	USUAL ACTIVITY LEVEL
Example: Crawling all around	Not crawling hardly at all	They used to be able to craw no problem