TREEHIVE
CHIROPRACTIC

PEDIATRIC FORM

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

Address_______________________________City____________________State______ Zip_______

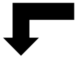
Pediatrician: ___________________________ May we contact them regarding your child's care? Yes No

Guardian(s) Name:___________________________Relationship:___________________________

Siblings:________________________________ Child's Social Security #:____________________

Phone Number:___________________________ Parent Email: ___________________________

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: ____________	____________	____________	____________	____________	____________

☐ No complaints, I'm here to use chiropractic care for my child's overall health and wellness

Has your child 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:

___ Abdominal Pain
___ ADHD/ADD
___ Allergies
___ Anxiety
___ Asthma
___ Autism
___ Bedwetting
___ Behavioral Issues
___ Bladder Problems
___ Blood Disorder
___ Chest Pain
___ Colic
___ Constipation
___ Depression
___ Dizziness
___ Diarrhea
___ Difficulty Swallowing
___ Digestive Issues
___ Double/Blurry Vision
___ Ear Infections
___ Excess Stress
___ Epilepsy/convulsions
___ Fatigue
___ Frequent cold/flu
___ Growing Pains
___ GERD/gastric reflux
___ Headaches
___ Heartburn
___ High Blood Pressure
___ Heart Problems
___ Hearing Loss
___ Hip/Leg Pain
___ Jaw Pain/TMJ
___ Jaundice
___ Joint pain/Stiffness
___ Juvenile Diabetes
___ Knee Pain
___ Low Back Pain
___Mid Back Pain
___Migraines
___Menstrual Changes
___ Moody/Irritable
___ Nausea
___ Neck Pain
___ Nervousness
___ Numb/Tingling Arms/Hands
___ Numb/Tingling Legs/Feet
___ Poor Posture
___ Persistent Cough
___ Rash/redness
___ Ringing in Ears
___ Seizures
___ Sinus problems
___ Sleep Difficulties
___ Sports Injury
___ Scoliosis
___ Tight/Sore Muscles
___ Torticollis
___ Ulcers
___ Upper Back Pain

Other:____

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Physical History:

Broken bones or major injuries ______________________________

Accidents or major trauma: ______________________________

Sports throughout life: ______________________________

Surgeries: ______________________________

Developmental delays: ______________________________

Previous illnesses: ______________________________

Number of doses of antibiotics your child has taken: Past 6 months__________ Total during lifetime______________

List current medications: ______________________________

Prenatal History

Type of prenatal care: OB/GYN Nurse Midwife Licensed Midwife

Complications during pregnancy: Yes No Explain: ______________________________

Ultrasounds during pregnancy: Yes No Explain: ______________________________

Medications while pregnant? Yes No List: ______________________________

Tobacco/Alcohol use? Yes No

Birth History

Location of birth: Home Birthing Center Hospital Other:______________________

Type of attendant: OB/GYN Nurse Midwife Licensed Midwife Doula

Intervention used: Forceps Vacuum Cesarean: Planned/ Emergency

Complications during delivery: Yes No Explain: ______________________________

Birth Weight: ______ **Birth Length:** _________

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. What is your child's typical or AVERAGE pain? (To the best of your knowledge)

____

0 1 2 3 4 5 6 7 8 9 10