Ancient City Chiropractic PEDIATRIC HISTORY FORM

PATIENT DEMOGRAPHICS HR#:_____

Today's Date_____/_____/____

Childs Name_____

Date of Birth_____/_____/_____ Age: _____

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

Address_____

City_____State_____ Zip_____Phone (Home)_____

Mother's Name:_____DOB__/__/__ Mother's Mobile _____

Father's Name:_____DOB_/_/ Father's Mobile _____

Pediatrician/Family MD_____City/State_____

Last Visit:____/____/____ Reason for visit:_____

Who is responsible for this bill? _____

☐ Father's Social Security #_____-_____-_____☐ Mother's Social Security _____

☐ Other *(please explain)*: _____

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 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?____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 EVER SUFFERED FROM: *Check all that apply*

☐ 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	☐ Asthma
☐ Sinus Trouble	☐ Poor Posture	☐ Hypertension	☐ Walking Trouble
☐ Scoliosis	☐ Anemia	☐ Colds/Flu	☐ Sleeping Problems
☐ Bed Wetting	☐ Colic	☐ Broken Bones	☐ Fall off swing
☐ Fall in baby walker	☐ Fall from bed or couch	☐ Fall from crib	☐ Fall down stairs
☐ Fall off bicycle	☐ Fall from high chair	☐ Fall off slide	
☐ Fall from changing table	☐ Fall off monkey bars	☐ Fall off skateboard/skates	

☐ Allergies to_____

☐ Other: _____

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

_____ _____

Parent or Legal Guardian's Signature Date

_____ _____

Doctor's Signature Date

ANCIENT CITY CHIROPRACTIC QVAS ENGLISH 2021-02

QUADRUPLE VISUAL ANALOGUE SCALE (QVAS) **Pt #**_____

Patient Name:_____ Date: _____

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** — **neck** — **Low Back** — **Worst possible pain**

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

1. How would you rate your pain or Symptom RIGHT NOW?

No pain — Worst pain

0 1 2 3 4 5 6 7 8 9 10

2. What is your TYPICAL or AVERAGE pain or Symptom?

No pain — Worst pain

0 1 2 3 4 5 6 7 8 9 10

3. What is your pain or Symptom level AT ITS BEST (How close to 0 does your pain get at its best?)

No pain — Worst pain

0 1 2 3 4 5 6 7 8 9 10

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

No pain — Worst pain

0 1 2 3 4 5 6 7 8 9 10

Score_____