Taylor Family CHIROPRACTIC

74 Main St. | Medway, MA 02053 Record # _____

Pediatric Exam form (0-10)

Name _____ **Today's Date**_____ **Birthdate** _____ **Age**_____

Guardian Name _____ **# of kids / ages** _____

Address _____ **City** _____ **State** _____ **Zip** _____

Home Phone _____ **Cell Phone** _____ **Occupation** _____ **Gender** ❑ M ❑ F ❑ O

E-Mail _____ **Have they been to a chiropractor before?** ❑ Yes ❑ No

Who May We Thank For Referring You To Our Office:_____

PRESENT COMPLAINTS (Please fill out in as much detail as possible If the child is to young to fill out the complaints move past them and fill out explanation for evaluation:

1._____ **How long has this been an issue?** _____

Is it: ❑ Constant (100%) ❑ Frequent (50-75%) ❑ Occasional (25-50%) ❑ Intermittent (1-25%) **Worse:** ❑ Morning ❑ Mid-day ❑ Night
❑ Dull ❑ Sharp ❑ Ache ❑ Stabbing ❑ Numb/Tingle ❑ Burn ❑ Other _____ ❑ **Pain radiates to:** _____
❑ Staying the same ❑ Getting worse ❑ Improving **Pain Scale: NO PAIN 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 WORST PAIN**
Relieved by: _____ **Aggravated by:** _____
Previous Episodes: ❑ Yes ❑ No Details: _____
Previous Care for this condition: ❑ Yes ❑ No _____ **Recent Testing:** ❑ Yes ❑ No _____

2._____ **How long has this been an issue?** _____

Is it: ❑ Constant (100%) ❑ Frequent (50-75%) ❑ Occasional (25-50%) ❑ Intermittent (1-25%) **Worse:** ❑ Morning ❑ Mid-day ❑ Night
❑ Dull ❑ Sharp ❑ Ache ❑ Stabbing ❑ Numb/Tingle ❑ Burn ❑ Other _____ ❑ **Pain radiates to:** _____
❑ Staying the same ❑ Getting worse ❑ Improving **Pain Scale: NO PAIN 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 WORST PAIN**
Relieved by: _____ **Aggravated by:** _____
Previous Episodes: ❑ Yes ❑ No Details: _____
Previous Care for this condition: ❑ Yes ❑ No _____ **Recent Testing:** ❑ Yes ❑ No _____

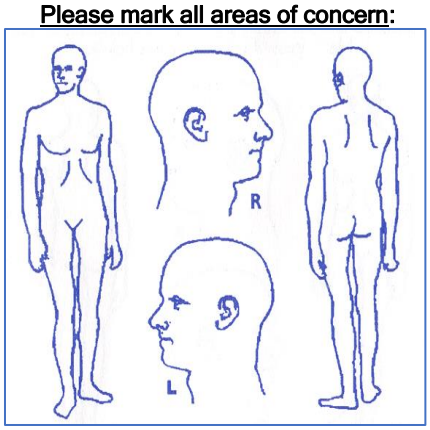
Details of the complaint: (IF COULD NOT BE FILLED OUT IN THE ABOVE SECTION)

_____

_____

_____

Please mark all areas of concern:



Does the condition affect his or her: ❑ Sleep ❑ Eating ❑ Daily Routine ❑ Sitting ❑ Thriving
What makes it better? _____
What makes it worse? _____
What doctors have you seen for this: _____
Type of treatment: _____

If the patient cant give verbal or visual pain level: What is the perceived pain by the guardian:
❑ Slight ❑ Moderate ❑ Moderate to severe ❑ Severe

Patient Name_____ **Date** _____

Patient/Guardian Signature _____ Dr. Signature_____

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Record # _____

Patient Name_____ Date: _____

PATIENT HISTORY

❑ **NO MEDICAL PROBLEMS - No prior history of any significant medical problems: Initial:_____**

Mark the conditions that apply to you:

Past	Present		Past	Present		Past	Present	
❑	❑	Headaches	❑	❑	Vision Problems	❑	❑	Dizziness/Fainting
❑	❑	Ear Infections	❑	❑	Sleeping Problems	❑	❑	Neck Issues
❑	❑	Colic	❑	❑	Growing Pains	❑	❑	Back Issues
❑	❑	Allergies / Asthma	❑	❑	Dental Problems	❑	❑	Arm/Leg Issues
❑	❑	Medication Side Effects	❑	❑	Temper Tantrums	❑	❑	Reflux
❑	❑	Recurring Fevers	❑	❑	ADHD	❑	❑	Constipation
❑	❑	Digestive problems	❑	❑	Seizures	❑	❑	Diarrhea
❑	❑	Bed Wetting	❑	❑	Scoliosis	❑	❑	Poor Posture
❑	❑	Chronic Colds/Sinus	❑	❑	Ever Needed Stitches			
❑	❑	Other _____						

❑ **Cancer (please give details):** _____

List any medications being taken:_____

Number of courses of antibiotics child has taken in the last 6 months.:_____ **Total during lifetime:**_____

Birth Weight:: _____ **Current Weight:**_____

Date of last pediatrician Visit: _____/_____/_____ **Reason:**_____

Name of pediatrician/obstetrician/midwife:_____

Location of Birth: ❑ **Hospital** ❑ **Birthing Center** ❑ **Home**

Complications during pregnancy: ❑ **No** ❑ **Yes Explain:**_____

Ultrasounds during pregnancy: ❑ **No** ❑ **Yes How Many?:**_____

Medication during pregnancy/delivery ❑ **No** ❑ **Yes List:**_____

Cigarette/alcohol use during pregnancy: ❑ **No** ❑ **Yes**

List any past auto collisions:_____ **Was any care received?**_____

List any past falls/bumps/bruises: _____ **Was any care received?**_____

List any past sport, recreational, or home injuries:_____

Please describe any past conditions and treatment received: _____

_____

Please list any past hospitalizations and surgeries: _____

_____

Father's side: □ Heart Disease □ Cancer □ Diabetes □ Heavy Medication use □ Arthritis □ Other_____

Mother's side: □ Heart Disease □ Cancer □ Diabetes □ Heavy Medication use □ Arthritis □ Other_____

Is there any other family history you want us to know?_____

Patient/Guardian Signature _____ Dr. Signature_____

Is Your Child Trying to Tell You Something?

Please check off all that apply:

Your child could be exhibiting symptoms of nervous system distress.

We want to help you get your child back!

Taylor Family Chiropractic

Flip page over for more

In your own words, please tell us more about your child and the signs they have been exhibiting :

Anything else we should know?

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