HANSON CHIROPRACTIC CENTER
DR. RYAN HANSON
1717 S BOULEVARD SUITE B
EDMOND, OK 73013
(405) 341-0494

PEDIATRIC HISTORY FORM

PATIENT DEMOGRAPHICS HR#:_____

Childs Name_____ Today's Date _____/_____/____

Date of Birth _____/_____/_____ Age: _____ Birth Height: _____ Birth Weight: _____
Current Height: _____Current Weight: _____

Address _____City _____ State _____
Zip _____ Phone (Home) _____

Mothers Name: _____Mother's Mobile _____DOB____/____/____

Fathers name: _____Father's Mobile_____DOB ____/____/____

Email_____

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 ____/____/_____ _____Gradual _____Sudden
2. **Ever had** this problem **before**? No_____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 _____Year
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_____

11. **HAS YOUR CHILD EVER SUFFERED FROM:** *mark a* **Y for** *YES OR* ***N*** *N*

□ 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 changing table
□ Fall off monkey bars □ Fall off skateboard/skates □ Other:

I understand that I am directly and fully responsible to Dr. Ryan Hanson 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

Please list below anyone whom you give legal access to Medical Records/ Accounting information:

_____	_____	_____
Name	Phone #	Relationship to Patient
_____	_____	_____
Name	Phone #	Relationship to Patient

Doctor Signature _____ Date_____

JDD,DC 5/2011