



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 _____