Pediatric Patient Health Record

Date: ____/_____/________

Child's History
Name: ____ Birth Date: ____ /_____/________ Age: _____ Gender: M/F
Address: ____Apt # ______
City: ______________ State: ______ Zip: _________ Home Phone: (_______) ____________-_____________
Social Security #: _________-_________-______________ State: _____

Name(s) of Parents / Guardians: ____________________________________
Referred to office by: __________________________ Relation to Patient: ___________________________

Emergency Contact
Name: ____ Phone Number: (_______) ________-__________
Address: ____
Relationship: _____________________________________

Who Is Responsible For Your Bill?
☐ Self ☐ Worker's Comp ☐ Auto Insurance ☐ Medicare ☐ Medicaid ☐ Other (be specific):_______________
Personal Health Insurance Carrier: __________________ Health ID Card #: ___________________________
Insured Person's Name: ___________________________ Group #: ___________________________________
Insured Person's Date of Birth: _____________________ Primary Care Physician: _____________________

Chief Complaint

Why is your child here today: ___________________________
____
____

Use the letters below to indicate the type and location of you sensations right now:
A= Ache B=Burning N=Numbness
P=Pins & Needles S=Stabbing O=Other

PLEASE LABEL ON THE DIAGRAM THE AREA OF DISCOMFORT

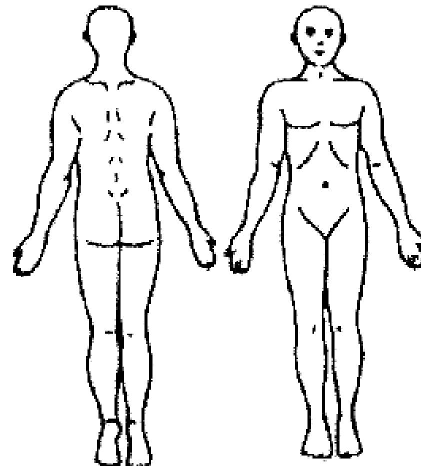
→ → → → → → →

When did this condition begin? _____/_______/_________
Has it ever occurred before? ☐ Yes ☐ No
When? ____

Is the condition: ☐ Auto Related ☐ No Injury ☐ Other

Has your child seen other doctors for this condition? ☐ Yes ☐ No
Name Doctor/Location of Office: _____________________________________

Currently taking any prescription medications? _________________
____



Type of Birth: Normal Breech Cesarean Vacuum Extraction Forceps
Problems during Labor / Delivery: no/yes ____

REVIEW OF SYSTEMS – Please fill out all of the sections, even if "DENY".

<u>Constitutional:</u> I… ☐ Deny Any Constitutional Issue (s)
☐ Fatigue ☐ Fever ☐ Night Sweats ☐ Weight Gain ☐ Weight Loss

<u>Ears, Nose and Throat:</u> I… ☐ Deny Any Ears, Nose and Throat Issue (s)
☐ Bleeding ☐ Difficulty Swallowing ☐ Discharge ☐ Dizziness ☐ Ear Drainage ☐ Ear Infection(s)
☐ Ear Pain ☐ Fainting ☐ Headaches ☐ Head Injury ☐ Hearing Loss ☐ Hoarseness
☐ Sinus Infections ☐ Sore Throats (frequent) ☐ Tinnitus (Ringing in Ears) ☐ TMJ problems ☐ Loss of Smell

<u>Respiration:</u> I… ☐ Deny Any Respiratory Issue (s)
☐ Asthma ☐ Cough ☐ Sputum Production ☐ Wheezing

Gastrointestinal: I… ☐ Deny Any Gastrointestinal Issue (s)

☐ **Abdominal Pain** ☐ **Belching** ☐ **Black, Tarry Stools** ☐ **Constipation** ☐ **Diarrhea**
☐ **Difficulty Swallowing** ☐ **Heartburn** ☐ **Hemorrhoids** ☐ **Indigestion** ☐ **Jaundice (yellowing of the skin)**
☐ **Nausea** ☐ **Rectal Bleeding** ☐ **Abnormal Stool Color** ☐ **Vomiting**

Nervous System: I… ☐ Deny Any Nervous System Issue (s)

☐ **Dizziness** ☐ **Facial Weakness** ☐ **Headaches** ☐ **Limb Weakness** ☐ **Loss of Consciousness**
☐ **Loss of Memory** ☐ **Numbness** ☐ **Seizures** ☐ **Sleep Disturbance** ☐ **Slurred Speech**
☐ **Stress** ☐ **Strokes** ☐ **Tremors**

PAST HEALTH HISTORY – Please fill out carefully as these problems can affect your overall course of care.

Childhood Illness: I… ☐ Deny Any Childhood Illness (es)

☐ **ADD** ☐ **Allergies/Hayfever** ☐ **Asthma** ☐ **Atopic Dermatitis (Eczema)** ☐ **Cerebral Palsy**
☐ **Chicken Pox** ☐ **Diabetes** ☐ **Ear Infections** ☐ **Fetal Drug Exposure** ☐ **Food Allergies**
☐ **Headaches** ☐ **Hepatitis** ☐ **Measles** ☐ **Mumps** ☐ **Rash**
☐ **Scoliosis** ☐ **Seizure Disorder** ☐ **Sickle Cell Anemia** ☐ **Other (please describe): _______________________**

Injuries: I… ☐ Deny Any Injury (ies)

☐ **Back Injury** ☐ **Broken Bones** ☐ **Severe Fall** ☐ **Fracture** ☐ **Head Injury**
☐ **Joint Injury** ☐ **Car Accident** ☐ **Mild/Moderate/Severe Soft Tissue Injury**

Daily Activities: Effects of Current Condition on Performance

Bending:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Carrying Groceries:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Change Posn–Sit-Stand:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Climb Stairs:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Extended Computer Use:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Feeding:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Household Chores:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Kneeling:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Lift Children:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Lifting:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Pet Care:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Reading (Concentration):	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Self Care–Bathing:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Self Care–Dressing:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Self Care–Shaving:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Sleep:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Static Sitting:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Static Standing:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Walking:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Yard Work:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform

Recreational Activity: Effects of Current Condition on Performance

____________________	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (limited)	☐ **Sev** Unable to Perform
____________________	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (limited)	☐ **Sev** Unable to Perform

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as he or she deems appropriate. It is understood and agreed the amount paid the Doctor, for x-rays, is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office.

Patient's Signature: ______________________________________ **Date:**__________________________

Consent to treat a Minor: _________________________________ **Date:**__________________________

Guardian or Spouse's
Signature of authorizing care: _____________________________ **Date:**__________________________