Pediatric Patient Information

Child's Name:_____ Date:_____ File#:_____

Date of Birth:_____ Age:_____ Sex: □Male □Female Number of Siblings:_____

Mother's Name:_____ Phone:_____ □Home □Work □Cell

Father's Name:_____ Phone:_____ □Home □Work □Cell

Address:_____ City:_____ State:_____ Zip:_____

Who referred you to our office?_____

Purpose of this appointment:_____

When did this problem begin:_____ Is this problem getting worse: □Yes □ No

Is this problem: □Constant □Comes & Goes Has the child had this complaint before? □Yes □ No

Is this problem worse during a certain part of the day?_____

Does this interfere with child's: □Sleep □Eating □Daily Routine □Other_____

What makes it better:_____ What makes it worse:_____

Other Doctor's Seen for this Condition:_____

Prior Treatments:_____

Other Health Problems:_____

Circle any of the Following Conditions Your Child has suffered from During the Past Six Months:

Ear Infections	Reflux	Colic	Frequent Colds	Developmental Issues
Asthma /Allergies	Digestive Problems	Poor Appetite	Constipation	Other _____

Number of Doses of Antibiotics Your Child Had Taken: In Past Six Months_____ In Lifetime_____

Has your child ever been treated on an emergency basis?_____

Pediatrician/Family MD:_____

Date of Last Visit:_____ Purpose:_____

We are here to provide you and your family with the best care possible and answer any questions you may have.

Thank you for trusting us with the care of your child.

Authorized For Care of Minor

I hereby authorize this office and its doctor(s) to administer care as they so deem, necessary to my Son/daughter/ward (upon approval of parent or guardian).

Signed:_____ Print Name:_____ Date:_____

I realize that I am responsible for all fees charged by this office and I agree to pay for all services provided. X-rays remain the property of this office.

Signed:_____ Date:_____

Prenatal History

Obstetrician/ Midwife:_____

Child's gestational age at birth:_____ Birth Weight:_____ Birth Length:_____

Third Trimester Presentation: ◻Vertex ◻ Breech ◻Transverse ◻Face/Brow

Type of Birth: ◻Normal Vagina ◻Forceps ◻Suction cup or Vacuum ◻Cesarean

Problems during Pregnancy:_____

Problems during Labor/Delivery:_____

Delivery/Labor History: _____

Genetic Disorders or Disabilities?_____

First Few Years

Infant Feeding: ◻Breast, How Long_____ ◻ Bottle, Which Formula_____

Number of Hours Sleeping per Night:_____ Quality of Sleep: ◻Good ◻Fair ◻Poor

Introduced to Solids at:_____ Any Intolerances:_____

During the following times your child's spine is most vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference). At what age was your child able to:

_____Respond to Sound _____ Cross Crawl _____Sit Up

_____Respond to Visual Stimuli _____ Stand Alone

_____Hold Head Up _____ Walk Alone

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e., a bed, changing table, down stairs, etc.). Was this the case with your child? ◻No ◻Yes

Chiropractic adjustments insure your brain is communicating with every organ in your body and therefore is an important part of health and wellness. Did you know chiropractic can improve the immune system, help with frequent colds, chronic ear aches, colic, reflux and many other aspects of a healthy body. If you want to know if chiropractic can help with anything in particular just ask us.