

PEDIATRIC PATIENT INTRODUCTION

CHILD'S NAME: _____ MOTHER'S NAME _____ DOB: _____

CASE NUMBER: _____ FATHER'S NAME _____ DOB: _____

ADDRESS: _____ CITY/TOWN: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ MOTHER'S WORK PHONE: _____ MOTHER'S CELL PHONE: _____

EMAIL: _____ FATHER'S WORK PHONE: _____ FATHER'S CELL PHONE: _____

BIRTH DATE: _____ AGE: _____ SEX: _____ NUMBER OF SIBLINGS: _____ REFERRED BY: _____

BIRTH WEIGHT: _____ BIRTH LENGTH: _____ CURRENT WEIGHT: _____ CURRENT LENGTH: _____

THIRD TRIMESTER PRESENTATION: VERTEX _____ BREECH _____ TRANSVERSE _____ FACE/BROW _____

TYPE OF BIRTH: NORMAL VAGINAL _____ FORCEPS _____ CESAREAN _____ SUCTION CAP OR VACUUM _____

LOCATION: HOME _____ BIRTHING CENTER _____ HOSPITAL _____

PROBLEMS DURING PREGNANCY: _____

PROBLEMS DURING LABOR/DELIVERY: _____

APGAR SCORES: _____ WAS THERE PRESENCE AT BIRTH OF: JAUNDICE (YELLOW)? _____ CYANOSIS (BLUE)? _____

CONGENITAL ANOMALIES/DEFECTS? _____ IF YES, PLEASE EXPLAIN _____

INFANT FEEDING: BREAST _____ BOTTLE _____ IF BOTTLE, WHICH FORMULA? _____

NUMBER OF HOURS SLEEPING PER NIGHT: _____ QUALITY OF SLEEP: GOOD _____ FAIR _____ POOR _____

OBSTETRICIAN/MIDWIFE: _____

PEDIATRICIAN/FAMILY MD: _____

DATE OF LAST VISIT: _____ PURPOSE: _____

IMMUNIZATION HISTORY: _____

NUMBER OF DOSES OF ANTIBIOTICS YOUR CHILD HAS TAKEN: DURING PAST 6 MONTHS _____ DURING HIS/HER LIFETIME _____

PREVIOUS CHIROPRACTOR: _____

DATE OF LAST VISIT: _____ PURPOSE: _____

HAS YOUR CHILD EVER BEEN TREATED ON AN EMERGENCY BASIS? _____ IF YES, PLEASE EXPLAIN: _____

PURPOSE OF THIS APPOINTMENT: _____

INSURANCE/BILLING INFORMATION: _____ POLICY #: _____

AUTHORIZATION 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: _____ WITNESSED: _____ DATE: _____

I RELIZED 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: _____

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DELIVERY/BIRTH HISTORY: _____

AT WHAT AGE DID THE CHILD:

RESPOND TO SOUND _____ FOLLOW AN OBJECT WITH HIS/HER EYES _____ HOLD HEAD UP _____
SIT ALONE _____ CRAWL _____ STAND _____ WALK ALONE _____

AT WHAT AGE, IF EVER, DID THIS CHILD SUFFER FROM THE FOLLOWING CHILDHOOD DISEASES?

CHICKEN POX _____ MUMPS _____ MEASLES _____ RUBELLA _____
RUBEOLA _____ WHOOPING COUGH _____ OTHER _____

HAS THIS CHILD EVER SUFFERED FROM:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> HEADACHES | <input type="checkbox"/> ORTHAPEDIC PROBLEMS | <input type="checkbox"/> DIGESTIVE DISORDERS | <input type="checkbox"/> BEHAVIORAL PROBLEMS |
| <input type="checkbox"/> DIZZINESS | <input type="checkbox"/> NECK PROBLEMS | <input type="checkbox"/> POOR APPETITE | <input type="checkbox"/> ADD/ADHD |
| <input type="checkbox"/> FAINTING | <input type="checkbox"/> ARM PROBLEMS | <input type="checkbox"/> STOMACH ACHES | <input type="checkbox"/> RUPTURES/HERNIA |
| <input type="checkbox"/> SEIZURES/CONVULSIONS | <input type="checkbox"/> LEG PROBLEMS | <input type="checkbox"/> REFLUX | <input type="checkbox"/> MUSCLE PAIN |
| <input type="checkbox"/> HEART TROUBLE | <input type="checkbox"/> JOINT PROBLEMS | <input type="checkbox"/> CONSTIPATION | <input type="checkbox"/> GROWING PAINS |
| <input type="checkbox"/> CHRONIC EARACHES | <input type="checkbox"/> BACKACHES | <input type="checkbox"/> DIARRHEA | <input type="checkbox"/> ALLERGIES TO _____ |
| <input type="checkbox"/> SINUS TROUBLE | <input type="checkbox"/> POOR POSTURE | <input type="checkbox"/> DIABETES | <input type="checkbox"/> ALLERGIES TO _____ |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> SCOLIOSIS | <input type="checkbox"/> HYPERTENSION | <input type="checkbox"/> ALLERGIES TO _____ |
| <input type="checkbox"/> COLD/FLU | <input type="checkbox"/> WALKING TROUBLE | <input type="checkbox"/> ANEMIA | <input type="checkbox"/> OTHER _____ |
| <input type="checkbox"/> COLIC | <input type="checkbox"/> BROKEN BONES | <input type="checkbox"/> BED WETTING | <input type="checkbox"/> OTHER _____ |

HAS THIS CHILD EVER SUFFERED FROM:

- | | | |
|---|--|--|
| <input type="checkbox"/> FALL IN BABY WALKER | <input type="checkbox"/> FALL FROM BEAD OR COUCH | <input type="checkbox"/> FALL OFF SKATEBOARD OR SKATES |
| <input type="checkbox"/> FALL FROM CRIB | <input type="checkbox"/> FALL OFF SWING | <input type="checkbox"/> FALL OFF BYCICLE |
| <input type="checkbox"/> FALL FROM HIGHCHAIR | <input type="checkbox"/> FALL OFF SLIDE | <input type="checkbox"/> FALL DOWN STAIRS |
| <input type="checkbox"/> FALL FROM CHANGING TABLE | <input type="checkbox"/> FALL OFF MONKEY BARS | <input type="checkbox"/> OTHER _____ |

HAS THIS CHILD EVER SUSTAINED AN INJURY PLAYING ORGANIZED SPORTS? _____ IF YES, PLEASE EXPLAIN: _____

HAS THIS CHILD EVER SUSTAINED AN INJURY IN AN AUTO ACCIDENT? _____ IF YES, PLEASE EXPLAIN: _____

PARENT HISTORY: _____

SURGERY: _____

MEDICATIONS: _____

ACCIDENTS: _____

FAMILY HISTORY: _____