



PEDIATRIC PATIENT INTRODUCTION

Child's Name: _____
 Mother's Name: _____ Father's Name: _____
 Address: _____ City: _____ 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: _____

Obstetrician/Midwife: _____
 Pediatrician/Family MD: _____
 Date of Last Visit: _____ Purpose: _____
 Immunization History: _____
 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: _____

Third Trimester Presentation: Vertex: _____ Breech: _____ Transverse: _____ Face/Brow: _____
 Type of Birth: Normal Vaginal _____ Forceps _____ Cesarean _____ Suction/Vacuum _____ Induced Labor _____
 Location: Home _____ Birthing Center _____ Hospital _____ Duration of Gestation: _____
 Problems during pregnancy: _____
 Problems during labor/delivery: _____
 Apgar Scores: _____ Was there presence at birth of: Jaundice (yellow)? _____ Cynosis (blue)? _____
 Congenital anomalies/defect? _____ If yes, please explain? _____

Chemical Stressors

During pregnancy, did the mother: 1. Smoke Y N 2. Drink alcohol? Y N
 3. Take supplements/ vitamins? Y N 4. Take drugs? Y N If yes, what? _____
 5. Become ill? If so, How? _____ 6. Receive ultrasounds? Y N If yes, how many? _____
 7. Receive invasive procedures? (ie. Amniocentesis, CVS) Y N If yes, explain: _____
 Was your child breast fed? Y N If yes, for how long? _____ weeks months years
 At what age was: 1a. Formula introduced? _____ b. Brand? _____ 2. Cow's milk? _____ yrs
 3. Solid foods? _____ yrs
 Did your child receive vaccinations? Y N If yes, which ones? _____
 Did your child react to them? Y N If yes, how so? _____
 Has your child had antibiotics? Y N If yes, how many and why? _____
 Any pets at home? Y N Any smokers at home? Y N If yes, how much? _____

Psychological Stressors

Any difficulties with lactation? Y N Any problems bonding? Y N
 Does your child seem normal to you? Y N
 Does your child have any behavior problems? Y N If yes, what? _____
 Does your child have difficulties sleeping (e.g. night terrors, sleepwalking, etc.)? _____
 Number of hours sleeping per night: _____ Quality of Sleep: Good _____ Fair _____ Poor _____
 Did your child go to daycare? Y N From what age? _____
 Average number of hours of TV/Computer per week? _____

Traumatic Stressors

Any evidence of trauma at birth? Bruises Odd shaped head Stuck in birth canal Fast/Long birth Respiratory Depression Cord around neck Other _____

Any falls/accidents during pregnancy? Y N If yes, please explain: _____

Any hospitalizations? Y N If yes, Please explain: _____

Does your child play sports? Y N Number of hours per week? _____ Age child began? _____

Has the child ever sustained injuries in an auto accident? Y N If yes, explain: _____

Weight of school backpack? _____ lbs Approx. hours spent at play per week? _____ hrs

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 _____ Vocalize _____

At what age, if ever, did this child suffer from the following childhood diseases?

Chickenpox _____ Mumps _____ Measles _____ Rubella _____
Rubeola _____ Whooping Cough _____ Other _____

Has this child ever suffered from:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Orthopedic 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/Convulsion | <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 | Allergies to _____ |
| <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Poor Posture | <input type="checkbox"/> Diabetes | Allergies to _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Hypertension | Allergies to _____ |
| <input type="checkbox"/> Colds/Flu | <input type="checkbox"/> Walking Trouble | <input type="checkbox"/> Anemia | Other _____ |
| <input type="checkbox"/> Colic | <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Bed Wetting | Other _____ |

Has this child ever suffered the following spinal traumas?

- | | | |
|---|--|--|
| <input type="checkbox"/> Fall in baby walker | <input type="checkbox"/> Fall from bed/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 bicycle |
| <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 of monkey bars | Other _____ |

Do the child's siblings have any health problems? Y N If yes, please explain? _____

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 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: _____

Insurance/Billing Information: _____ Policy #: _____