PEDIATRIC PATIENT HISTORY

Name of Child: ______________________________________ SS# __________________________
DOB: ___________ Grade in School:__________ Gender: M / F Main Phone #: _________________
Address: ____________________________ City: _________________ State: _____ Zip: ________
Mother's Name: __________________________________ Main Phone #: _____________________
Father's Name: ___________________________________ Main Phone #: _____________________
Referred By: ________________________________ Pediatrician: __________________________

Would you like Dr. Carlin to send her findings to update your Pediatrician? Y/N

It seems that patients greatly benefit when their health care providers work together.

Purpose of this Appointment: ____
____
____
Siblings & Ages: ____
Are mom and dad currently under chiropractic care? Y/ N   Have the kids been adjusted before? Y/ N
How does this condition affect family members? ____
____

Pregnancy History (Mother): (If child is adopted, answer to the best of your ability)
Did you experience any of the following during pregnancy:

- o Severe viral infection during pregnancy 1st trimester
- o Breech position during pregnancy
- o Accident or infections
- o Smoking
- o Severe stress
- o Pre-eclampsia
- o Alcohol consumption and or drug use
- o Radiation exposure
- o Hypertension (High Blood pressure)
- o Toxoplasmosis
- o Uncontrolled Diabetes
- o Toxemia

Labor and Delivery History: Did you experience any of the following during labor/delivery:

- o Hospital Birth
- o Birthing home
- o Long and/or difficult birth
- o Placenta previa
- o Forceps or suction cup used
- o Fetal distress
- o Elective C-section
- o The child was a "blue baby"
- o Home birth
- o Labor was induced
- o Delivery was rapid
- o Breech birth
- o Cord around the neck
- o Breech birth
- o Emergency C-section
- o The child was premature (2+ weeks)

Newborn History: Did the child experience any of the following as a newborn:

- o Required resuscitation/oxygen
- o Prolonged Jaundice
- o Poor sleeper
- o Immunizations in hospital
- o If yes, specify vaccine: ________________ ___________________________________
- o Distorted Skull
- o Difficulty latching/sucking
- o Formula fed
- o Breast fed
- o Bottle fed
- o Colic
- o Weight at Birth:_________________
- o Length at Birth:_________________

Health History: Has your child ever experienced the following or been diagnosed as having any of the following:

- o Illness accompanied by a high fever
- o Frequent headaches
- o Seizures/convulsions
- o Chronic ear infections/earaches
- o Meningitis

Patient Name: ____ Date: _________________

(continued)

- Head injury
- Serious Fall(s) or repetitive falls
- Serious illness
- Epilepsy
- Meningitis
- Allergies to foods
- Environmental allergies
- Chemical Insensitivities
- Undergone any surgeries
- Neck or back problems
- Adverse reaction to any vaccinations (even if mild): __________________________
- Dizziness
- Diabetes
- Hypoglycemia (low blood sugar)
- Trouble with bladder control (enuresis)
- Fainting
- High blood pressure
- Heart disease
- Asthma
- Sinus problems
- Constipation
- Diarrhea
- Digestive disorders
- Rheumatic fever
- Joint or muscle problems

Developmental History: Does or did your child have any of the following:

- Difficulty with crawling (on all fours)
- Difficulty learning to ride a bike
- Difficulty learning to read
- Difficulty using utensils
- Difficulty tying shoes
- Poor hand-eye coordination
- At what age did your child learn to walk unassisted: _________________
- Did not crawl on all fours
- Appears Clumsy
- Difficulty with writing
- Difficulty buttoning clothing
- Difficulty or awkward with walking/running
- Difficulty sitting still or paying attention

Neurological/Other: Has your child ever been diagnosed by a medical professional with any of the following, if yes, by whom:

- Hearing loss or impairment
- Neurological disorders
- Obsessive Compulsive Disorder (OCD)
- ADD/ADHD
- Dyslexia
- Visual impairment
- Anxiety/Depression
- Autism/Autism Spectrum Disorder
- Tourette's Syndrome
- Other: ________________

Current/Past Medications and Treatment: List any medications that your child is taking: (List names, dose and frequency): ____

____

____

List any special dietary needs that your child has:____

____

List any supplements that your child takes:____

____

List any special services that your child is currently receiving at school or privately:______________

____

List any special dietary needs that your child has:____

____

List any treatment that your child is currently undergoing with any health professional:___________

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PEDIATRIC PATIENT HISTORY

Patient Name: ____ Date: _________________

List any previous chiropractic treatment, medications or other medical treatment that your child has undergone:____
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____
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Comments: ____
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AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize Dr. Stacy Carlin, DC, CACCP to evaluate and treat my son/daughter as she deems necessary.

I also acknowledge that I am financially responsible for any and all fees charged by this office and that payment will be made as services are provided. I also understand that any x-rays taken at this office are property of this clinic.

____ ____________________________
Signature and relation of person completing this form Date

____ ____________________________
Signature of Witness Date