PEDIATRIC PATIENT INTRODUCTION

Child's Name: _____ Mother's Name: _____

Child's DOB: _____ Age: _____ Sex: ___ Father's Name: _____

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

Home Phone: _____ Mother's Phone: _____ Father's Phone: _____

Email: _____ # of siblings: _____

Referred by: _____

Birth Weight: _____ Birth Length: _____ Current weight: _____ Current Length:_____

Third Trimester Presentation: _____Vertex (head down) ____Breech ___Transverse ___Face/ Brow

Type of Birth: ___Normal vaginal ___ Forceps ___ Planned Cesarean

____ Emergency 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/ Night: _____ Quality of Sleep: Good ____ Fair ____ Poor _____

Obstetrician/ Midwife: _____ Pediatrician/ Family MD: _____

Date of Last Visit: _____ _____ _____ Purpose: _____

Immunization History: _____

# of doses of antibiotics your child has taken: In the past 6 Months: _____ During his/her lifetime: ____

Previous Chiropractor: _____ Date of Last Visit: ___-___-____

Purpose for today's visit: _____

Has Your Child Ever Been Treated On An Emergency Basis? _____ If Yes, Please Explain: _____

_____

AUTHORIZATION FOR CARE OF MINOR

I HEREBY AUTHORIZE THIS OFFICE AND ITS DOCTOR(S) TO ADMINISTER CARE AS THEY DEEM NECESSARY TO MY SON/DAUGHTER/WARD (UPON APPROVAL OF PARENT OR GUARDIAN)

SIGNED: _____ DATE: _____

WITNESS:_____

I REALIZE THAT I AM RESPONSIBLE FOR ALL FEES CHARGED BY THIS OFFICE AND I AGREEE TO PAY FOR ALL SERVICES PROVIDED

SIGNED: _____ DATE:_____

Has your child ever suffered from:

_____ Headaches	_____ Orthopedic Problems	_____ Digestive Disorders
_____ Dizziness	_____ Neck Problems	_____ Poor Appetite
_____ Fainting	_____ Arm Problems	_____ Stomach Aches
_____ Seizures/ Convulsions	_____ Leg Problems	_____ Reflux
_____ Heart Trouble	_____ Joint Problems	_____ Constipation
_____ Chronic Earaches	_____ Backaches	_____ Diarrhea
_____ Sinus Trouble	_____ Poor Posture	_____ Diabetes
_____ Asthma	_____ Scoliosis	_____ Hypertension
_____ Colds/ Flu	_____ Walking Trouble	_____ Anemia
_____ Colic	_____ Broken Bones	_____ Bed Wetting
_____ Behavioral Problems	_____ ADD/ ADHD	_____ Ruptures/ Hernias
_____ Muscle Pains	_____ Growing Pains	_____ Allergies to: _____

_____ Other: _____

Are there any concerns with the developmental progress of your child? Yes/ No If yes, please explain: _____

_____

Has your child ever suffered from the follow spinal traumas?

_____ Fall in baby walker	_____ Fall from bed or couch	_____ Fall off skateboard or skates
_____ Fall from crib	_____ Fall off swing	_____ Fall off bicycle
_____ Fall from high chair	_____ Fall off slide	_____ Fall down stairs
_____ Fall from changing table	_____ Fall off monkey bars	_____ Other: _____

Has your child ever sustained an injury playing organized sports? _____ If yes, please explain: _____

_____

Has your child ever sustained an injury in an auto accident? _____ If yes, please explain: _____

_____

Any history of surgeries? Yes/ NO If yes, please explain: _____

Please list any medications your child is taking: _____

_____

Please list any supplements or vitamins your child is taking: _____

_____

How would you rate your child's diet? Fair Poor Good Excellent

What are your child's favorite foods? _____

How many hours does your child sit watching TV, playing video games, or on the computer/ tablet?

0-2 hours/ day 3-4 hours/ day 5-6 hours/ day 7+ hours/ day

Does your child use a backpack at school? Yes/ No

If yes, what is the estimated weight of the backpack? _____