PEDIATRIC PATIENT INFORMATION

CHILD'S NAME____ BIRTHDATE:_______________________GENDER________

MOTHER'S NAME____FATHER'S NAME________________________________

ADDRESS_______________________________________CITY__________________________STATE______ZIP_________

PHONE___________________________ ALTERNATE PHONE____________________________

FAMILY EMAIL:____

PEDIATRICIAN/FAMILY MD/DO:____

DATE OF LAST VISIT:________________________ PURPOSE:____

NUMBER OF SIBLINGS___________ AGES:____

Who can we *Thank* for referring you to our office?__________________________

BIRTH WEIGHT:______________ BIRTH LENGTH:____________ CURRENT WEIGHT:_________CURRENT LENGTH:________

THIRD TRIMESTER PRESENTATION: (CIRCLE) VERTEX(HEAD DOWN), BREECH, TRANSVERSE, FACE/BROW

DURATION OF GESTATION: ________WEEKS WAS MOTHER INDUCED: YES / NO EPIDURAL: YES / NO

TYPE OF BIRTH: (CIRCLE) NORMAL VAGINAL, CESAREAN, FORCEPS, SUCTION CUP/VACUUM

LOCATION OF BIRTH: (CIRCLE) BIRTHING CENTER, HOSPITAL, HOME

WERE MEDICATIONS GIVEN TO MOTHER DURING LABOR/BIRTH: YES / NO IF YES, WHAT?____________________

HOW LONG WAS LABOR:________________________ HOW LONG PUSHING;_________________

PROBLEMS DURING PREGNANCY: ____

PROBLEMS DURING LABOR/DELIVERY: ____

APGAR SCORES: ________ ________ PRESENCE AT BIRTH OF: JAUNDICE (YELLOW)? YES / NO CYANOSIS (BLUE)? YES / NO

CONGENITAL ANOMALIES/DEFECTS? YES / NO IF YES, PLEASE EXPLAIN____

INFANT FEEDING: BREASTMILK: YES / NO BOTTLE: AGE INTRODUCED__________________

PREFERENCE FOR ONE SIDE WHILE FEEDING? LEFT / RIGHT PAINFUL LATCH FOR MOTHER? YES / NO

NEEDING TO SUPPLEMENT? YES / NO IF YES, SUPPLEMENTING WITH: DONOR MILK OR FORMULA? (CIRCLE)

FORMULA INTRODUCED: YES / NO AT WHAT AGE? _________________ BRAND:________________________________

DOES INFANT TAKE A PACIFIER: YES / NO

ANY CONCERNS WITH BOWEL/BLADDER HABITS? (APPEARANCE, FREQUENCY, ETC.)______________________________________

HOURS SLEEPING PER NIGHT:____________ WAKING EVERY ___________ HOURS

DESCRIBE FAMILY HISTORY OF HEALTH PROBLEMS THAT EXIST (INDICATE MOTHER OR FATHER'S SIDE):

____

____

ANY SIBLINGS WITH HEALTH PROBLEMS/CONCERNS, OR SCOLIOSIS?____

CHEMICAL STRESSORS:

DURING PREGNANCY, DID THE **MOTHER:**

SMOKE/USE TOBACCO YES / NO HOW MUCH:__________, DRINK ALCOHOL: YES / NO HOW MUCH_________________,

USE DRUGS: YES / NO TAKE SUPPLEMENTS/VITAMINS: YES / NO LIST:____

TAKE MEDICATIONS: YES / NO LIST:____

BECOME ILL: YES / NO IF SO, HOW?___________________________, RECEIVE INVASIVE PROCEDURES:________________

RECEIVE VACCINATIONS DURING PREGNANCY? YES / NO

DID YOUR CHILD RECEIVE VACCINATIONS?: YES / NO IF YES, WHICH ONES?_____________________________________

DID YOUR CHILD HAVE ANY REACTIONS TO VACCINATIONS? YES / NO DESCRIBE:______________________________

NUMBER OF DOSES OF ANTIBIOTICS TAKEN DURING PAST SIX MONTHS:_________________ LIFETIME:____________

CURRENT MEDICATIONS:____

ANY SMOKERS AT HOME?______________WHO, AND HOW MUCH?____

PSYCHOLOGICAL STRESSORS:

MOTHER HAVE DIFFICULTIES WITH LACTATION? YES / NO ANY PROBLEMS BONDING? YES / NO

DOES THE CHILD HAVE ANY BEHAVIOR PROBLEMS?____

DOES THE CHILD HAVE DIFFICULITY SLEEPING (NIGHT TERRORS, SLEEP WALKING, ETC):__________________________________

DOES YOUR CHILD GO TO DAYCARE? YES / NO FROM WHAT AGE?______

AVG. NUMBER OF HOURS TV/COMPUTER PER WEEK?___________ HANDHELD DEVICES___________________________

TRAUMATIC STRESSORS:

ANY EVIDENCE OF TRAUMA DURING BIRTH? (CIRCLE) BRUISES, ODD SHAPED HEAD, STUCK IN BIRTH CANAL,

RESPIRATORY DEPRESSION, CORD AROUND NECK, OTHER:____________________________

HAS THE CHILD HAD ANY MAJOR FALLS SINCE BIRTH? YES / NO NEED STICHES OR CAUSE A FRACTURE? YES / NO

ANY CAR ACCIDENTS? YES / NO TYPE OF ACCIDENT?____________________WAS ANYONE INJURED?_______________

ANY HOSPITALIZATIONS/SURGERIES? YES / NO PLEASE EXPLAIN:____

DOES YOUR CHILD PLAY SPORTS? YES / NO HOURS PER WEEK?__________ AGE CHILD BEGAN?__________

SPORTS/ACTIVITIES:____

ADDRESSING THE ISSUES THAT BROUGHT YOU TO THE OFFICE:

As a family chiropractic office, we focus on your child's ability to be healthy. Our goals are: first, to address the issues that brought you to this office, and second, to offer you and your child the opportunity of improved health potential and complete wellness services.

Briefly describe the chief area of complaint, including the effect it has on the child:

____

____

WHEN DID THIS BEGIN?____

IS THE CHILD EXPERIENCING PAIN?__________ (CIRCLE): SHARP, DULL/ACHY, VARYING, TRAVELS, CONSTANT

SINCE THE PROBLEM STARTED, IS IT: (CIRCLE) ABOUT THE SAME, GETTING BETTER, GETTING WORSE

WHAT MAKES IT WORSE:_________________________________ BETTER:____________________________________

IT INTERFERES WITH: (CIRCLE) SCHOOL, SLEEP, WALKING, HOBBIES/SPORTS, OTHER:______________________

OTHER DOCTORS SEEN FOR THIS PROBLEM:____

If your child has no symptoms or complaints, and is here for wellness services, please check here ☐.

(WELLNESS CARE IS NOT COVERED BY INUSRANCE)

………

AUTHORIZATION FOR CARE OF MINOR

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

SIGNED:__________________________________ RELATIONSHIP:______________________ DATE:_______________