Brent
Family Chiropractic

PEDIATRIC PATIENT INFORMATION

CHILD'S NAME_____ D.O.B.:_____ SEX_____

MOTHER'S NAME_____FATHER'S NAME_____

ADDRESS_____CITY_____STATE_____ZIP_____

HOME 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, BREECH, TRANSVERSE, FACE/BROW

DURATION OF GESTATION: _____WEEKS

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:_____ IF YES, WHAT?_____

PROBLEMS DURING PREGNANCY: _____

PROBLEMS DURING LABOR/DELIVERY: _____

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

CONGENITAL ANOMALIES/DEFECTS? _____IF YES, PLEASE EXPLAIN_____

INFANT FEEDING: BREAST:_____HOW LONG?_____ BOTTLE: AGE INTRODUCED_____

PREFERENCE FOR ONE SIDE WHILE FEEDING?_____

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

HOURS SLEEPING PER NIGHT:_____ QUALITY OF SLEEP: (CIRCLE) GOOD, FAIR, POOR

DESCRIBE ANY HEALTH PROBLEMS THAT EXIST ON THE MOTHER'S SIDE OF THE FAMILY: _____

_____

THE FATHER'S SIDE:_____

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

CHEMICAL STRESSORS:

DURING PREGNANCY, DID THE **MOTHER:**

SMOKE/USE TOBACCO:_____HOW MUCH:_____, DRINK ALCOHOL:_____HOW MUCH_____,

USE DRUGS:_____TAKE SUPPLEMENTS/VITAMINS:_____ LIST:_____

TAKE MEDICATIONS:_____ LIST:_____

BECOME ILL:_____ IF SO, HOW?_____, RECEIVE INVASIVE PROCEDURES:_____

DID YOUR CHILD RECEIVE VACCINATIONS?:_____IF YES, WHICH ONES?_____

DID YOUR CHILD HAVE ANY REACTIONS TO VACCINATIONS?_____ DESCRIBE:_____

NUMBER OF DOSES OF ANTIBIOTICS TAKEN DURING PAST SIX MONTHS:_____ LIFETIME:_____

CURRENT MEDICATIONS:_____

ANY PETS AT HOME?_____

ANY SMOKERS AT HOME?_____WHO, AND HOW MUCH?_____

PSYCHOLOGICAL STRESSORS:

MOTHER HAVE DIFFICULTIES WITH LACTATION?_____ ANY PROBLEMS BONDING?_____

DOES THE CHILD HAVE ANY BEHAVIOR PROBLEMS?_____

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

DOES YOUR CHILD GO TO DAYCARE?_____ FROM WHAT AGE?_____

AVG. NUMBER OF HOURS TV/COMPUTER PER WEEK?_____

TRAUMATIC STRESSORS:

ANY EVIDENCE OF TRAUMA DURING BIRTH? (CIRCLE) BRUISES, ODD SHAPED HEAD, STUCK IN BIRTH CANAL,
RESPIRATORY DEPRESSION, CORD AROUND NECK, OTHER:_____

FAST OR EXCESSIVELY LONG BIRTH?_____

HAS THE CHILD HAD ANY MAJOR FALLS SINCE BIRTH?_____ NEED STICHES OR CAUSE A FRACTURE?_____

ANY CAR ACCIDENTS?_____TYPE OF ACCIDENT?_____WAS ANYONE INJURED?_____

ANY HOSPITALIZATIONS/SURGERIES?_____ PLEASE EXPLAIN:_____

DOES YOUR CHILD PLAY SPORTS?_____ HOURS PER WEEK?_____ AGE CHILD BEGAN?_____

SPORTS/ACTIVITIES:_____

WEIGHT OF SCHOOL BACKPACK:_____

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 wellness services.

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

others need to 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:_____

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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:_____