Pediatric Patient Introduction

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

Today's Date:_____ Father's Name:_____ DOB:_____

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

Home Phone:_____ Mother's Work #: _____Mother's Cell#_____

Email:_____ Father's Work #_____Father's Cell#_____

Birth Date:_____ Age:____ Sex:_____ Number of Siblings:_____ Referred By:_____

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

Third Trimester Presentation: Vertex_____ Breech_____ Transverse_____ Face/Brow_____

Type of Birth: Normal Vaginal_____ Forceps_____ Cesarean_____ Suction Cap or Vacuum_____

Location: Home_____ Birthing Center_____ Hospital_____

Problems During Pregnancy:_____

Problems During Labor:_____

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 Per Night:_____ Quality of Sleep: Good_____ Fair_____ Poor_____

Obstetrician/Midwife:_____

Pediatrician/Family MD:_____

Date of Last Visit:_____ Purpose:_____

Immunization History:_____

Number of doses of antibiotics your child has taken: During past six months: _____ During lifetime:_____

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:_____

Insurance Company:_____ Policy _____

Authorization for Care of Minor

I herby authorize this office and its Doctor(s) to administer care as they deem necessary to my son/daughter/ward (upon approval of parent of 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:_____

Family Chiropractic Wellness Center
750 Swift Blvd, Richland, WA 99352

Pediatric Case History

Delivery/Birth History: _____

_____

_____

_____

At what age did the child:

Respond to Sound:_____ Follow an Object with Eyes:_____ Hold up Head:_____

Sit Alone:_____ Crawl:_____ Stand:_____ Walk Alone:_____

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

Chickenpox:_____ Mumps:_____ Measles:_____ Rubella:_____

Rubeola:_____ Whooping Cough:_____ Other:_____

Has the child ever suffered from:

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

Has the child ever suffered from the following 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 highchair	☐ Fall off slide	☐ Fall down stairs
☐ Fall from changing table	☐ Fall off monkey bars	☐ Other:_____

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

_____

Has the child ever sustained injuries in a car accident?_____ If yes, please explain:_____

_____

Present History:_____

_____

_____

Surgeries:_____

Medications:_____

Accidents:_____

Family History: _____

_____