CHIROPRACTIC CONCEPTS

New Pediatric Patient Information

Child's Name: ____________________________ Account # __________________Date: _________________

Address: ________________________________ City ______________________ State______ Zip ___________

Home phone: ____________________ Mother's Name: ____

Mother's cell phone: _________________________ Mother's work phone: ______________________________

Father's Name: _________________________________ Father's cell phone: ___________________________

Father's work phone: ___________________________ E-mail: ____

Who was patient referred by: ____

Birth Date: ________ ________ ____________ Age: _______ Sex: ______ Number of siblings: ___________

Birth weight: ____________ Length: ___________ Current weight: ____________ Length: _______________

Third trimester presentation: Vertex _______ Breech _______ Transverse _______ Face/Brow ___________

Type of birth: Normal Vaginal ______ Forceps ______ Cesarean ______ Suction Cap or Vacuum _________

Birth location: Home ________ Birthing Center _________ Hospital _________ Other __________________

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 per night: __________ Quality of sleep: Good _______ Fair _______ Poor _______

Obstetrician/Midwife: ____________________________Pediatrician/Family M.D.: ______________________

Date of last visit: ____________________ Purpose: ____

Immunization history: ____

Number of doses of antibiotics you child has taken: Past 6 months __________ his/her lifetime ____________

Previous Chiropractor: ______________________________________ Date of last visit: __________________

Purpose: ____

Has your child ever been treated on an emergency basis? _______ Please explain: _____________________

Purpose for this appointment: _________________________Insurance/Billing: __________________________

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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

Signed ____ **Date** _______________________

CHIROPRACTIC CONCEPTS

Pediatric Case History

Patient Name: ____ Date: _________________________

At what age did the child:

Respond to sound __________ Follow an object with his/her eyes_________ Hold head up ________

Sit alone ____________ Crawl ____________ Stand ____________ Walk alone ____________

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

Chickenpox __________ Mumps __________ Measles __________ Rubella __________

Rubeola __________ Whooping cough __________ Other __________________________________

Has the child ever suffered from? (Check all that apply)

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

Has this child ever suffered 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 high chair	◯ Fall off slide	◯ Fall down stairs
◯ Fall from changing table	◯ Fall off monkey bars	◯ Other ________________________

Has this child ever sustained an injury playing organized sports? _______ If yes, please explain: ____________

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Has this child ever sustained injuries in an auto accident? _______ If yes, please explain:_________________

Surgeries:____________________________________ Accidents:________________________________

Medications:_________________________________ Family history:_____________________________

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