

**PEDIATRIC PATIENT INTRODUCTION**

Child's Name: \_\_\_\_\_ Mother's Name: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Father's Name: \_\_\_\_\_

Address: \_\_\_\_\_ City/Town: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Mother's Work Phone: \_\_\_\_\_ Mother's Cell: \_\_\_\_\_

E-mail: \_\_\_\_\_ Father's Work Phone: \_\_\_\_\_ 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/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 MD: \_\_\_\_\_

Date of Last Visit: \_\_\_\_/\_\_\_\_/\_\_\_\_ Purpose: \_\_\_\_\_

Immunization History: \_\_\_\_\_

Number of Doses Of Antibiotics Your Child Has Taken During: The Past 6 Months: \_\_\_\_ His/Her 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: \_\_\_\_\_

**Authorization For Care Of Minor**

I hereby authorize this office and its doctor(s) to administer care as they so deem necessary to my  
SON / DAUGHTER / WARD (Upon approval of parent or 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: \_\_\_\_/\_\_\_\_/\_\_\_\_

**PEDIATRIC CASE HISTORY**

Delivery/Birth History: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

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:

Chicken Pox: \_\_\_\_\_ Mumps: \_\_\_\_\_ Measles: \_\_\_\_\_ Rubella: \_\_\_\_\_

Rubeola: \_\_\_\_\_ Whooping Cough: \_\_\_\_\_ Other: \_\_\_\_\_

Has This Child Ever Suffered From:

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Headaches            | <input type="checkbox"/> Orthopedic Problems | <input type="checkbox"/> Digestive Disorders | <input type="checkbox"/> Behavioral Problems |
| <input type="checkbox"/> Dizziness            | <input type="checkbox"/> Neck Problems       | <input type="checkbox"/> Poor Appetite       | <input type="checkbox"/> ADD/ADHD            |
| <input type="checkbox"/> Fainting             | <input type="checkbox"/> Arm Problems        | <input type="checkbox"/> Stomach Aches       | <input type="checkbox"/> Ruptures/Hernia     |
| <input type="checkbox"/> Seizures/Convulsions | <input type="checkbox"/> Leg Problems        | <input type="checkbox"/> Reflex              | <input type="checkbox"/> Muscle Pain         |
| <input type="checkbox"/> Heart Trouble        | <input type="checkbox"/> Joint Problems      | <input type="checkbox"/> Constipation        | <input type="checkbox"/> Growing Pains       |
| <input type="checkbox"/> Chronic Earaches     | <input type="checkbox"/> Backaches           | <input type="checkbox"/> Diarrhea            | <input type="checkbox"/> Allergies _____     |
| <input type="checkbox"/> Sinus Trouble        | <input type="checkbox"/> Poor Posture        | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Allergies _____     |
| <input type="checkbox"/> Asthma               | <input type="checkbox"/> Scoliosis           | <input type="checkbox"/> Hypertension        | <input type="checkbox"/> Allergies _____     |
| <input type="checkbox"/> Colds/Flu            | <input type="checkbox"/> Walking Trouble     | <input type="checkbox"/> Anemia              | <input type="checkbox"/> Other _____         |
| <input type="checkbox"/> Colic                | <input type="checkbox"/> Broken Bones        | <input type="checkbox"/> Bed Wetting         | <input type="checkbox"/> Other _____         |

Has This Child Ever Suffered The Following Spinal Traumas:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Fall In Baby Walker      | <input type="checkbox"/> Fall From Bed Or Couch | <input type="checkbox"/> Fall Off Skateboard or Skates |
| <input type="checkbox"/> Fall From Crib           | <input type="checkbox"/> Fall Off Swing         | <input type="checkbox"/> Fall Off Bicycle              |
| <input type="checkbox"/> Fall From Highchair      | <input type="checkbox"/> Fall Off Slide         | <input type="checkbox"/> Fall Down Stairs              |
| <input type="checkbox"/> Fall From Changing Table | <input type="checkbox"/> Fall Off Monkey Bars   | <input type="checkbox"/> Other _____                   |

Has This Child Ever Sustained An Injury Playing Organized Sports: \_\_\_\_\_ If Yes, Please Explain: \_\_\_\_\_

Has This Child Ever Sustained Injuries In An Auto Accident: \_\_\_\_\_ If Yes, Please Explain: \_\_\_\_\_

Present History: \_\_\_\_\_

Surgery: \_\_\_\_\_

Medications: \_\_\_\_\_

Accidents: \_\_\_\_\_

Family History: \_\_\_\_\_