PEDIATRIC HEALTH INFORMATION

Welcome to our office! Please give us the following details about your child, their life events, and their health. If you do not understand any of these questions, please feel free to ask.

Personal Information

Patient's Name:_____

Parents / Guardians:_____

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

Home Phone:_____ Date of Birth:_____ Age:_____

Gender: ☐ Male ☐ Female Siblings:_____ Birth Weight:_____ Length:_____

In Case Of Emergency Notify: _____ Phone:_____

Family Physician / Pediatrician: _____

Obstetrician/Midwife:_____

Your E-Mail:_____

Who Should We Thank For Telling You About Our Office? _____

Current Health Concern

Primary Reason for Today's Visit: _____

_____

Check the Severity of the Complaint: (Mild) ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ (Severe)

When Did This Begin?_____ Experienced Previously? ☐ Yes ☐ Never

Is This Condition: ☐ Illness Related ☐ Auto Accident ☐ Fall or Injury ☐ Other:_____

Other Doctors Seen For This Problem:_____

Other Doctor's Opinions or Diagnosis: _____

Drugs or Medications Now Taking: ☐ Antibiotics ☐ Tranquilizers
☐ ADD/ADHD Meds ☐ Pain Killers
☐ Other:_____

Past Health History

3rd Trimester Presentation: Vertex____ Breech____ Transverse_____Face/Brow_____

Type of Birth: ☐ Vaginal ☐ Forceps ☐ Vacuum extraction ☐ Caesarian section

Complications during pregnancy: ☐ yes ☐ no describe:_____

Complications during delivery: ☐ yes ☐ no describe:_____

Apgar Score:_____ Was there presence of Jaundice ____ Cyanosis (blue)_____

Congenital Anomalies/Defects?____ If Yes, Explain_____

Previous fractures or broken bones: ☐ yes ☐ no describe:_____

Previous falls or accidents: ☐ yes ☐ no describe:_____

Previous hospitalization: ☐ yes ☐ no describe:_____

Previous chiropractic care: ☐ yes ☐ no describe:_____

Similar problem in family: ☐ yes ☐ no describe:_____

Began to walk alone at age: _____ Immunization History:_____

Feeding history: ☐ breast fed ☐ formula fed until age:_____

Introduced to solid foods at age: _____

PEDIATRIC HEALTH HISTORY

Check Any of the Following That May Apply

Child's Health Issues:

☐ Ear Infections	☐ Arthritis	☐ Heart	☐ Sleep Disorders
☐ Other Infections	☐ Colic	☐ Endocrine	☐ Fevers
☐ Growing Pains	☐ Chronic Fatigue	☐ Asthma	☐ Frequent Illnesses
☐ Epilepsy	☐ Genetic Disorders	☐ Colic	☐ Scoliosis
☐ Bed Wetting	☐ Over Weight	☐ Tantrums	☐ Seizures
☐ Under Weight	☐ Digestive Disorders	☐ Other_____	

Other Complaints

Muscles-Skeleton

- ☐ Low Back Pain
- ☐ Middle Back
- ☐ Neck
- ☐ Hips / Legs
- ☐ Joint Pain
- ☐ Shoulders/Arms

Circulation-Breathing

- ☐ Chest Pain
- ☐ Lungs/Breathing
- ☐ Blood Pressure
- ☐ Heart Rate
- ☐ Poor Circulation
- ☐ Coughing or Wheezing

Eye-Ear-Nose-Throat

- ☐ Eyes / Vision
- ☐ Dental / TMJ
- ☐ Throat / Voice
- ☐ Ears / Hearing
- ☐ Sinus Pain / Drainage

Check Any Complaints Your Child May Have Had In the Last Six Months

Nerve System

- ☐ Headaches
- ☐ Nervousness
- ☐ Numbness
- ☐ Weak Muscles
- ☐ Dizziness
- ☐ Forgetfulnes
- ☐ Depression
- ☐ Fainting
- ☐ Change In Stools

Digestion-Elimination

- ☐ Poor Appetite
- ☐ Excessive Thirst
- ☐ Nausea
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Weight Loss / Gain
- ☐ Heartburn

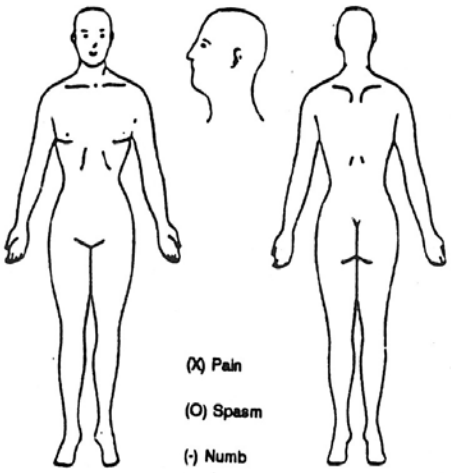
Urinary-Genitals

- ☐ Pain With Urination
- ☐ Infrequent Urination
- ☐ Frequent Urination
- ☐ Weak Stream
- ☐ Bladder Control
- ☐ Genital Pain or Symptoms
- ☐ Stress Reactions
- ☐ Cold Hands / Feet

Female Only

- ☐ Menstrual Problems
- ☐ Back Pain w/ Period
- ☐ Breast Lumps/Pain
- ☐ Birth Control Pills

Please Mark Areas Of Concern



I understand that the care of my child involves the making of judgements that are based upon the facts known by the doctor. Therfore, the above information is true and complete to the best of my knowledge.

I hereby request and authorize the examining and the subsequent rendering of chiropractic care to my child.

_____

Parent or Gaurdians Signature: