Pediatric Patient Information

Childs Full Name: _____ Date: _____

Name Child Uses (nickname): _____ Birthday: _____ Age: _____

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

Primary Phone Number: _____ Best Time to Call: _____

Mothers Name: _____ Fathers Name: _____

Email: _____

Number of Siblings: _____ Age of Siblings: _____ Referred by: _____

Name and Number of Person to Contact if we Cannot Reach You: _____

The practice of chiropractic is based upon the location and adjustment of vertebral subluxations. These spinal subluxations are caused by any stress to which your body cannot adapt. These stresses may be **physical, chemical** or **emotional** in nature.

Additional Information

_____

_____

_____

_____ _____

Patient Signature (Parent) Doctor Signature

Child History

Today Date: _____

Patients Name: _____ Sex: M F Date of Birth: _____ Age: _____

Has your child been formally diagnosed with anything? Y N If yes, explain:

_____

The following questions are designed to help the doctor provide the best possible spinal care for your child.
Please circle either yes or no and explain if needed

LABOR AND DELIVERY

How long was the labor from the first regular contraction to the birth? _____ hours

How long was the 2nd stage (pushing phase) of the labor? _____ hours

Hospital birth? **Yes No** _____

Home Birth? **Yes No** _____

Midwife assisted? **Yes No** _____

Vaginal Delivery? **Yes No** _____

Planned C-Section? **Yes No** _____

Emergency C-Section? **Yes No** _____

Was Birth Induced? (Pitocin) **Yes No** _____

Forceps Delivery? **Yes No** _____

Vacuum Extraction? **Yes No** _____

Anesthesia Administered? **Yes No** _____

Fetal Distress? **Yes No** _____

Meconium Staining? **Yes No** _____

Head Presentation? **Yes No** _____

Face Presentation? **Yes No** _____

Breech Presentation? **Yes No** _____

BABY'S CONDITION IMMEDIATELY AFTER BIRTH:

Apgar Scores: At 1 Minutes _____/10 At 5 Minutes _____/10

Baby's Crying: Baby Cried Immediately After Birth: _____

Cried Strong _____ Weak Cry _____ Did Not Cry for ____ minutes

Baby's Color: Pink all over _____ Blue Face _____ Blue Hands/Feet _____

Intensive Care: Was required _____ Days in Neonatal Intensive Care Unit _____

Medication given at birth? _____ Vaccines administered:_____

Birth weight: _____ lbs/kgs Birth length: _____ ins/cms Day you took baby home: _____

NUTRITION

Is your child being breast fed? **Yes No** If no, how long were they being breast fed? _____

If still being breast fed, how much cows milk does Mom consume each day? _____

Is your child formula fed? **Yes No** If yes, which formula/milk source is being used? _____

Is your child eating solid foods? **Yes No** If yes, which foods are contained in their diet? _____

Does your child have any feeding difficulties? **Yes No** _____

Does your child have any food allergies? **Yes No** _____

Does your child have any persistent or intermittent skin rashes? **Yes No** _____

Is your child receiving any vitamin supplements? **Yes No** If yes, which ones? _____

Do you have any concerns about your child's diet? **Yes No** _____

Does your child have any digestive disturbances? **Yes No** _____

Does your child eliminate stool's each day? **Yes No** _____

What does your child usually eat for breakfast? _____

What does your child usually eat for lunch? _____

What does your child usually eat for dinner? _____

What does your child usually eat for snacks; favorite food? _____

How much cow's milk does your child drink each day? _____

How much water does your child drink each day? _____

How much soda does your child drink each day? _____

What type of fast foods does your child like to eat and how often? _____

TRAUMA

Has your child had any recent falls or trauma? **Yes No** _____

If yes, describe the trauma and the date it occurred: _____

_____

Has your child ever fallen down stairs or fallen from any heights? **Yes No** _____

Has your child ever fallen from a bicycle, skateboard, scooter, rollerblades or similar? **Yes No** _____

Has your child ever been in a motor vehicle collision or near-miss? **Yes No** _____

Has your child ever had a bone fracture or joint dislocation? **Yes No** If yes, please explain: _____

_____

Has your child had any other trauma or injuries? **Yes No** If yes, please explain: _____

_____

Does your child ever bang his/her head repeatedly against a wall, bed or other object? **Yes No** _____

GROWTH AND DEVELOPMENT

Can your child sit unsupported? **Yes No** At what age did your child start to sit-up? _____ mnths

Is your child crawling yet? **Yes No** At what age did your child start to crawl? _____ mnths

Is your child walking yet? **Yes No** At what age did your child start to walk? _____ mnths

Does your child often trip and fall? **Yes No** _____

Do you have any concerns about your child's growth and development? Yes No _____

_____

HEALTH HISTORY

Has your child had colic? **Yes No** _____

Has your child had any upper respiratory infections? **Yes No** If yes, how often? _____

Has your child had asthma? **Yes No** _____

Does your child ever complain of back or neck pain? **Yes No** _____

Does your child ever complain of pains in their arms or legs? **Yes No** _____

Does your child ever complain of headaches? **Yes No** _____

Has your child had any earaches? **Yes No** If yes, at what age did the first earache occur? _____

How often do they occur? _____

Left ear, Right ear or both? _____

Has your child had any other illnesses? **Yes No** If yes, please explain with dates: _____

_____

Is your child presently receiving any medications? **Yes No** If yes, which ones? _____

Has your child ever been to a hospital or emergency room for evaluation or treatments? Yes No If yes, please explain: _____

Has your child been recently vaccinated? **Yes No** _____

Do you have any other concerns about your child's health? **Yes No** _____

_____

LIFESTYLE

What grade is your child in? _____

How does your child carry their books? _____

How heavy is your childs school backpack? _____

What sports does your child play? _____

What hobbies does your child have? _____

How many hours a day does your child watch TV? _____

Use the computer? _____

Playing video games? _____

On average, how many hours does your child sleep every night? _____

Are their any smokers in the child's family? **Yes No** _____

Does your child feel stressed out? **Yes No** _____

Does your child have blurred vision? **Yes No** _____

Does your child wear glasses or contact lenses? **Yes No** _____

Does your child sometimes get headaches when they read? **Yes No** _____