

PEDIATRIC PATIENT INTRODUCTION

CHILD'S NAME: _____ MOTHER'S NAME: _____ DOB: _____
CASE NUMBER: _____ FATHER'S NAME: _____ DOB: _____
ADDRESS: _____ CITY/TOWN: _____ STATE: _____ ZIP: _____
HOME PHONE: _____ MOTHER'S WORK PHONE: _____ MOTHER'S CELL PHONE: _____
EMAIL: _____ FATHER'S WORK PHONE: _____ FATHER'S CELL PHONE: _____

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 SIX MONTHS _____ DURING 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: _____
INSURANCE/BILLING INFORMATION: _____ POLICY #: _____

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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?

CHICKENPOX _____ 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"/> REFLUX | <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 TO _____ |
| <input type="checkbox"/> SINUS TROUBLE | <input type="checkbox"/> POOR POSTURE | <input type="checkbox"/> DIABETES | <input type="checkbox"/> ALLERGIES TO _____ |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> SCOLIOSIS | <input type="checkbox"/> HYPERTENSION | <input type="checkbox"/> ALLERGIES TO _____ |
| <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: _____

History of Birth

Hospital / Birthing Center: Home Medical Midwife

Duration of Gestation: _____ weeks

Was the birth assisted? Yes No If yes, how? Forceps Vacuum Extraction C-Section Induced Labour

Were medications given to the mother at birth? Yes No If yes, what? _____ Duration of Birth: _____

Was the delivery normal? No Yes If no, what complications were there at birth? _____

APGAR at Birth _____ APGAR after 5 minutes _____ Birth Weight _____ Birth Length _____

Growth and Development

Was the infant alert & responsive within 12 hours of the delivery? Yes No If no, explain: _____

At what age did the child: Respond to sound? _____ Follow an object? _____ Hold up head? _____ Vocalize? _____

Sit alone? _____ Teethe? _____ Crawl? _____ Walk? _____ Do his/her sleeping patterns seem normal? Yes No

Describe any health problems that exist on the mother's side of the family? (e.g. Cancer, Diabetes etc.) _____

The father's side? _____

Do the child's siblings have any health problems? Yes No If yes, describe: _____

The following information is very important because many of the problems that chiropractors work with are caused by stressors.

Chemical Stressors

During pregnancy, did the mother: 1. Smoke Yes No 2. Drink alcohol? Yes No 3. Take supplements/vitamins? Yes No

4. Take drugs? Yes No If yes, what? _____ 5. Become ill? If so, how? _____

5. Receive ultrasounds? Yes No If yes, how many? _____ 6. Receive invasive procedures (ie. amniocentesis, CVS)? Yes No

Was your child breast fed? Yes No If yes, for how long? _____ weeks months years

At what age was: 1a. Formula introduced? _____ b. Brand? _____ 2. Cow's milk? _____ yrs 3. Solid foods? _____ yrs

Did your child receive vaccinations? Yes No If yes, which ones? _____ Did your child react to them? Yes No

Has your child had antibiotics? Yes No If yes, how many courses has the child had so far & why? _____

Any pets at home? Yes No Any smokers at home? Yes No If yes, how much? _____

Psychological Stressors

Any difficulties with lactation? Yes No Any problems bonding? Yes No Does your child seem normal to you? Yes No

Does the child have any behaviour problems? Yes No If yes, what? _____

Does your child have difficulties sleeping (e.g. night terrors, sleepwalking, etc.)? Yes No If yes, specify: _____

Did your child go to daycare? Yes No From what age? _____ yrs Average no. of hours of TV/Computer per week? _____ hrs

Traumatic Stressors

Any evidence of trauma during birth? Bruises Odd shaped head Stuck in birth canal Fast and/or excessively long birth

Respiratory Depression Cord around neck Other _____

Any falls/accidents during pregnancy? Yes No Has the child had any major falls since birth? Yes No If yes, did the child need stitches or cause a fracture? Please describe: _____

Any hospitalizations? Yes No Please explain: _____

Does your child play sports? Yes No Number of hours per week? _____ Age child began _____ yrs

Weight of school backpack? _____ lbs Approx. Hours spent at play per week? _____ hrs