PEDIATRIC PATIENT INFORMATION

CHILD'S NAME ____ REFERRED BY ______________________________

BIRTH DATE _____________________________ AGE________________ SEX________________ # OF SIBLINGS _________________

MOTHER'S NAME ____ DOB ______________________________

FATHER'S NAME ____ DOB ______________________________

ADDRESS _______________________________________ CITY/TOWN ______________________ STATE _________ ZIP__________

HOME PHONE ______________________ WORK PHONE: MOTHER'S ______________________ FATHER'S ______________________

EMAIL ____________________________ CELL PHONE: MOTHER'S ______________________ FATHER'S ______________________

OBSTETRICIAN / MIDWIFE ____

PEDIATRICIAN / FAMILY DOCTOR ____

DATE OF LAST VISIT______________________ PURPOSE ____

IMMUNIZATION HISTORY ____

OF DOSES OF ANTIBIOTICS YOUR CHILD HAS TAKEN: DURING THE PAST 6 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 VISIT ____

PEDIATRIC CASE HISTORY

DELIVERY / BIRTH HISTORY ____

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BIRTH WEIGHT _____________ BIRTH LENGTH_____________ CURRENT WEIGHT_____________ CURRENT LENGTH_____________

3RD TRIMESTER PRESENTATION: VERTEX ___________ BREECH___________ TRANSVERSE___________ FACE/BROW___________

TYPE OF BIRTH: NORMAL VAGINAL__________ FORCEPS__________ CESAREAN__________ SUCTION CAP / 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?______________________________________

HOURS SLEEP PER NIGHT_______________ QUALITY OF SLEEP: GOOD_______________ FAIR________________ POOR_______________

AT WHAT AGE DID THIS 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:

- ❑ HEADACHES
- ❑ DIZZINESS
- ❑ FAINTING
- ❑ SEIZURES/CONVULSIONS
- ❑ ARM PROBLEMS
- ❑ LEG PROBLEMS
- ❑ JOINT PROBLEMS
- ❑ BACKACHES
- ❑ POOR POSTURE
- ❑ SCOLIOSIS
- ❑ WALKING TROUBLE
- ❑ BROKEN BONES
- ❑ DIGESTIVE DISORDERS
- ❑ HEART TROUBLE
- ❑ CHRONIC EARACHES
- ❑ SINUS TROUBLE
- ❑ ASTHMA
- ❑ POOR APPETITE
- ❑ STOMACH ACHES
- ❑ REFLUX
- ❑ CONSTIPATION
- ❑ DIARRHEA
- ❑ DIABETES
- ❑ HYPERTENSION
- ❑ ANEMIA
- ❑ BED WETTING
- ❑ COLD/FLU
- ❑ COLIC
- ❑ ORTHOPEDIC PROBLEMS
- ❑ NECK PROBLEMS
- ❑ BEHAVIORAL PROBLEMS
- ❑ ADD/ADHD
- ❑ RUPTURE/HERNIA
- ❑ MUSCLE PAIN
- ❑ GROWING PAINS
- ❑ ALLERGIES TO _____________
- ❑ ALLERGIES TO _____________
- ❑ OTHER _____________________
- ❑ OTHER _____________________

HAS THIS CHILD EVER SUFFERED THE FOLLOWING SPINAL TRAUMAS?

- ❑ FALL IN BABY WALKER
- ❑ FALL FROM ROCKING CHAIR
- ❑ FALL FROM CHANGING TABLE
- ❑ FALL FROM BED OR COUCH
- ❑ FALL OFF SWING
- ❑ FALL OFF SLIDE
- ❑ FALL OFF MONKEY BARS
- ❑ FALL OFF SKATEBOARD OR SKATES
- ❑ FALL OFF BICYCLE
- ❑ FALL DOWN STAIRS
- ❑ 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 ____

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SURGERY____

MEDICATIONS____

ACCIDENTS ____

FAMILY HISTORY ____

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