

# 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 #: \_\_\_\_\_

## 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: \_\_\_\_\_