



### Pediatric Patient Introduction

Today's Date: \_\_\_\_\_

#### PATIENT INFORMATION:

Child's Name: \_\_\_\_\_ Child's Nickname: \_\_\_\_\_

Reason for Visit: \_\_\_\_\_

Sex: M / F Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Child's SSN: \_\_\_\_\_

Child's Address and Phone (if different from yours): \_\_\_\_\_

Who may we thank for referring you? \_\_\_\_\_

#### FAMILY INFORMATION:

Mother's Name: \_\_\_\_\_ Father's Name: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Home & Work Phone: \_\_\_\_\_ Home & Work Phone: \_\_\_\_\_

Parents Marital Status: Married \_\_\_\_ Single \_\_\_\_ Divorced \_\_\_\_ Widowed \_\_\_\_

List ages of other children in family: \_\_\_\_\_

Predominant language used at home: \_\_\_\_\_

#### PAYMENT INFORMATION:

If you have insurance that may cover chiropractic services, please provide your current insurance card so that we may make a copy. Additionally, please enter the following information relating to the person who is responsible for the child's health insurance coverage.

Insured's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ SS# \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Phone No.: \_\_\_\_\_

Employer: \_\_\_\_\_ Group #: \_\_\_\_\_ Insured's

☐ ID: \_\_\_\_\_

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered.

#### PREGNANCY HISTORY

What was the term of your pregnancy? \_\_\_\_\_ weeks

#### DURING YOUR PREGNANCY, DID YOU HAVE ANY OF THE FOLLOWING:

Yes/No

Falls \_\_\_\_\_

Motor Vehicle Accidents \_\_\_\_\_

Near-miss MVA \_\_\_\_\_

High Blood Pressure \_\_\_\_\_

Diabetes \_\_\_\_\_

Anemia \_\_\_\_\_

Morning Sickness \_\_\_\_\_

Indigestion \_\_\_\_\_

Seizures \_\_\_\_\_

Swollen Ankles \_\_\_\_\_

Thyroid Problems \_\_\_\_\_

Heart Problems \_\_\_\_\_

Back Pain \_\_\_\_\_

Abnormal Bleeding \_\_\_\_\_

Were you Hospitalized \_\_\_\_\_ Any Other Illnesses (list) \_\_\_\_\_

#### DURING YOUR PREGNANCY, DID YOU USE ANY OF THE FOLLOWING:

Yes/No

Tobacco \_\_\_\_\_

Alcohol \_\_\_\_\_

Non-Prescribed Drugs \_\_\_\_\_ Prescription Medications \_\_\_\_\_

Over-the-counter meds (list) \_\_\_\_\_

## **BIRTH HISTORY**

### **LABOR AND DELIVERY**

How long was the labor from the first regular contractions to the birth? \_\_\_\_\_ hours

How long was the 2<sup>nd</sup> stage (the pushing phase) of the labor? \_\_\_\_\_ hours

Yes/No

Hospital Birth \_\_\_\_\_ Home Birth \_\_\_\_\_

Midwife Assisted \_\_\_\_\_ Vaginal Delivery \_\_\_\_\_

Planned C-Section \_\_\_\_\_ Emergency C-Section \_\_\_\_\_

Was Birth Induced \_\_\_\_\_ Forceps Delivery \_\_\_\_\_

Vacuum Extraction \_\_\_\_\_ Anesthesia Administered \_\_\_\_\_

Fetal Distress \_\_\_\_\_ Meconium Staining \_\_\_\_\_

Head Presentation \_\_\_\_\_ Face Presentation \_\_\_\_\_

Breech Presentation \_\_\_\_\_

### **BABY'S CONDITION IMMEDIATELY AFTER BIRTH: (If Known)**

Apgar Scores: At 1 minute \_\_\_\_\_/10 At 5 minutes \_\_\_\_\_/10

Baby's Crying: Baby Cried Immediately After Birth \_\_\_\_\_ Cried Strongly \_\_\_\_\_

Weak Cry \_\_\_\_\_ Did Not Cry for \_\_\_\_\_ minutes

Baby's Color: Pink All Over \_\_\_\_\_ Blue Face \_\_\_\_\_ Blue Hand / Feet \_\_\_\_\_

Baby's Activity: Arms and Legs Actively Moving \_\_\_\_\_ Floppy Baby \_\_\_\_\_

Intensive Care Was Required \_\_\_\_\_ Days in Neonatal Intensive Care Unit \_\_\_\_\_

Medication Given at Birth? \_\_\_\_\_

Vaccines Administered \_\_\_\_\_

Birth Weight \_\_\_\_\_ lbs / kgs Birth Length \_\_\_\_\_ ins / cms Baby Home on Day \_\_\_\_\_

## **INFANT HISTORY**

The following questions are designed to help the doctor provide a detailed evaluation of your child.

### **NUTRITION:**

Yes/No

Is your child still being breast fed? If no, for how long was he / she breast fed? \_\_\_\_\_

If still breast feeding, how much cow's milk does the mother consume each day? \_\_\_\_\_

Is your child formula fed? Which formula or other milk source? \_\_\_\_\_

Is your child eating solid food? What foods does his / her diet contain? \_\_\_\_\_

What is your child's favorite food? \_\_\_\_\_

Does your child have any feeding difficulties? \_\_\_\_\_

Does your child have any digestive disturbances? \_\_\_\_\_

Does your child have any food allergies? \_\_\_\_\_

Does your child have any persistent or intermittent skin rashes? \_\_\_\_\_

Is your child receiving any vitamin supplements? \_\_\_\_\_

### **TRAUMA:**

Yes/No

Has your child had any recent falls or trauma? (What and When) \_\_\_\_\_

Has your child ever fallen down stairs or fallen from any height? (Where and When) \_\_\_\_\_

Has your child ever been in a motor vehicle collision or near-miss? (What and When) \_\_\_\_\_  
Has your child ever had a bone fracture or joint dislocation? (Where) \_\_\_\_\_  
Has your child had any other trauma or injuries? (Describe) \_\_\_\_\_  
Does your child ever bang his / her head repeatedly against a wall, bed or other object? \_\_\_\_\_

### **GROWTH AND DEVELOPMENT:**

Yes/No

Can your child sit unsupported? At what age did your child start to sit-up? \_\_\_\_\_ months  
Is your child crawling yet? At what age did your child start crawling? \_\_\_\_\_ months  
Is your child walking yet? At what age did your child start walking? \_\_\_\_\_ months  
Does your child often trip and fall? \_\_\_\_\_  
Do you have any other concerns about your child's growth and development? \_\_\_\_\_

### **HEALTH HISTORY:**

Yes/No

Does your child ever complain of back or neck pain? \_\_\_\_\_  
Does your child ever complain of pains in the arms or legs? \_\_\_\_\_  
Does your child ever complain of headaches? \_\_\_\_\_  
Has your child had any earaches? At what age did the first earache occur? \_\_\_\_\_  
How frequently does your child have earaches? \_\_\_\_\_  
Do your child's earaches usually tend to occur in the same ear? Is it the right or left ear? \_\_\_\_\_

Which of the following has your child experienced? Indicate "C" (current) or "P" (past):

<input type="checkbox"/> Skin conditions	<input type="checkbox"/> Digestive complaints	<input type="checkbox"/> Growing pains
<input type="checkbox"/> Easy bruising	<input type="checkbox"/> Difficulty sleeping	<input type="checkbox"/> Allergies
<input type="checkbox"/> Colic	<input type="checkbox"/> Seizures	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Asthma	<input type="checkbox"/> Constipation	<input type="checkbox"/> Diarrhea
<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Autism	<input type="checkbox"/> Learning disabilities
<input type="checkbox"/> Sinus troubles	<input type="checkbox"/> Nausea/Vomiting	<input type="checkbox"/> Upper Respiratory Infections
<input type="checkbox"/> Bed wetting	<input type="checkbox"/> Chicken pox	<input type="checkbox"/> Mononucleosis
<input type="checkbox"/> Impetigo	<input type="checkbox"/> Measles	<input type="checkbox"/> Bronchitis
<input type="checkbox"/> Frequent infections	<input type="checkbox"/> Strep throat	<input type="checkbox"/> Thrush
<input type="checkbox"/> Diaper rash	<input type="checkbox"/> Urinary tract infections	<input type="checkbox"/> Asthma

Has your child had any other illnesses? Please list each illness and its approximate date \_\_\_\_\_  
\_\_\_\_\_  
Is your child presently receiving any medications? \_\_\_\_\_  
Has your child ever been to a hospital or emergency room for evaluation or treatment? \_\_\_\_\_  
Has your child recently been vaccinated? \_\_\_\_\_  
Do you have any other concerns about your child's health? \_\_\_\_\_

Any Other Important Info:

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✓We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.

✓Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for any expenses incurred in collecting your account.

✓I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

✓I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in medical status.

Signature \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Patient \_\_\_\_\_