PEDIATRIC PATIENT INTRODUCTION

Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mother’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Case Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Father’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 Cup 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: \_\_\_\_\_\_\_ Quantity 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 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 the child suffer from the following childhood diseases?

Chickenpox \_\_\_\_\_\_\_\_ Mumps \_\_\_\_\_\_\_\_ Measles \_\_\_\_\_\_\_\_ Rubella \_\_\_\_\_\_\_\_

Rubeola \_\_\_\_\_\_\_\_ Whopping Cough \_\_\_\_\_\_\_\_ Other \_\_\_\_\_\_\_\_

Has this child ever suffered from:

|  |  |  |  |
| --- | --- | --- | --- |
| □ Headaches | □ Orthopedic Problems | □ Digestive Disorder | □ Behavioral Problems |
| □ Dizziness | □ Neck Problems | □ Poor Appetite | □ ADD/ADHD |
| □ Fainting | □ Arm Problems | □ Stomach Aches | □ Ruptures/Hernia |
| □ Seizures/Convulsions | □ Leg Problems | □ Reflux | □ Muscle Pain |
| □ Heart Trouble | □ Joint Problems | □ Constipation | □ Growing Pains |
| □ Chronic Earaches | □ Backaches | □ Diarrhea | □ Allergies to\_\_\_\_\_\_\_\_\_ |
| □ Sinus Trouble | □ Poor Posture | □ Diabetes | □ Allergies to \_\_\_\_\_\_\_\_ |
| □ Asthma | □ Scoliosis | □ Hypertension | □ Allergies to \_\_\_\_\_\_\_\_ |
| □ Colds/Flu | □ Walking Trouble | □ Anemia | □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| □ Colic | □ Broken Bones | □ Bed Wetting | □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_ |

Has this child ever suffered the following Spinal Traumas?

|  |  |  |
| --- | --- | --- |
| □ Fall in baby walker | □ Fall from bed or couch | □ Fall off skateboard or skates |
| □ Fall from crib | □ Fall off swing | □ Fall off bicycle |
| □ Fall from highchair | □ Fall off slide | □ Fall down stairs |
| □ Fall from changing table | □ Fall off monkey bars | □ 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PresentHistory:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Surgery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Accidents: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family History: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_