

## PEDIATRIC FORM (ages 0-3)

### Section 1: Patient Information

Full Name: \_\_\_\_\_

Preferred Name: \_\_\_\_\_  Male  Female Date of Birth \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Patient's SSN (last 4): \_\_\_\_\_ Email: \_\_\_\_\_

Parent(s)/Guardian(s) Name \_\_\_\_\_ SSN (last 4): \_\_\_\_\_

Phone Number: Cell (\_\_\_\_) \_\_\_\_\_ Home (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

### Section 2: Current Health Condition

What health condition(s) brings your child to our office? Please explain \_\_\_\_\_

If your child is experiencing pain or discomfort please identify where and for how long \_\_\_\_\_

When did the symptoms appear? \_\_\_\_\_ Has it ever occurred before?  Yes  No

Was it due to an accident?  Yes  No If yes, please explain \_\_\_\_\_

Are the symptoms?  Constant (100-75%)  Frequent (75-50%)  Intermittent (50-25%)  Occasional (25-1%)

Is this condition getting  Better  Worse or is it staying the  Same?

Does anything make the problem better?  Yes  No If yes, what \_\_\_\_\_

Does anything make the problem worse?  Yes  No If yes, what \_\_\_\_\_

Have you seen any other doctors for this?  Yes  No If yes, please list doctor's name and treatment if any \_\_\_\_\_

### Section 3: Medications

### Vitamins/Supplements

### Allergies

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

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

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

Parent/Guardian's Signature: \_\_\_\_\_

Date: \_\_\_/\_\_\_/\_\_\_

## Section 4: Medical History

Using the codes below, please fill in **EVERY** blank with the applicable letter.

**C** = Current Health Condition      **P** = Past Health Condition      **N** = Never had this Health Condition

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> ADHD/ADD             | <input type="checkbox"/> Cancer             | <input type="checkbox"/> Hernia            | <input type="checkbox"/> Psychiatric Care    |
| <input type="checkbox"/> Allergies            | <input type="checkbox"/> Chronic Colds      | <input type="checkbox"/> Kidney Disease    | <input type="checkbox"/> Reflux              |
| <input type="checkbox"/> Anemia               | <input type="checkbox"/> Colic              | <input type="checkbox"/> Migraines         | <input type="checkbox"/> RSV                 |
| <input type="checkbox"/> Anxiety/Depression   | <input type="checkbox"/> Constipation       | <input type="checkbox"/> Mononucleosis     | <input type="checkbox"/> Scoliosis           |
| <input type="checkbox"/> Asthma               | <input type="checkbox"/> Diarrhea           | <input type="checkbox"/> Muscle Pain       | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Autism/Spectrum Dis. | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Nausea/Vomiting   | <input type="checkbox"/> Sore Throat         |
| <input type="checkbox"/> Autoimmune Dis.      | <input type="checkbox"/> Dizziness/Vertigo  | <input type="checkbox"/> Neck Pain         | <input type="checkbox"/> Skin Problems       |
| <input type="checkbox"/> Back Pain            | <input type="checkbox"/> Ear Infections     | <input type="checkbox"/> Nosebleed         | <input type="checkbox"/> Sleeping Problems   |
| <input type="checkbox"/> Bed Wetting          | <input type="checkbox"/> Epilepsy/Seizures  | <input type="checkbox"/> Numbness/Tingling | <input type="checkbox"/> Toe Walking         |
| <input type="checkbox"/> Behavior Problems    | <input type="checkbox"/> Fatigue            | <input type="checkbox"/> Pneumonia         | <input type="checkbox"/> Torticollis         |
| <input type="checkbox"/> Bleeding Disorder    | <input type="checkbox"/> Headaches          | <input type="checkbox"/> Poor Appetite     | <input type="checkbox"/> Tumors/Growths      |
| <input type="checkbox"/> Broken Bones         | <input type="checkbox"/> Hearing Problems   | <input type="checkbox"/> Poor Motor Skills | <input type="checkbox"/> Ulcers              |
| <input type="checkbox"/> Bronchitis           | <input type="checkbox"/> Heart Problems     | <input type="checkbox"/> Poor Posture      | <input type="checkbox"/> Weight Problems     |

Please list any other complaints / conditions your child currently has or has had in the past \_\_\_\_\_

Please list all broken bones/injuries/major falls/surgeries/hospitalizations your child has had and the date they occurred \_\_\_\_\_

Is there anything else the doctor should know?  Yes  No If yes, please describe \_\_\_\_\_

## Section 5: Family History

Does anyone in your family suffer from the same condition(s) or other chronic illnesses?  Yes  No

If yes, whom and what condition(s) \_\_\_\_\_

## Section 6: Chiropractic History

Has your child ever seen a Chiropractor before?  Yes  No Date of most recent visit \_\_\_\_\_

For what reason was he/she seen? \_\_\_\_\_ Was he/she helped?  Yes  No

Parent/Guardian's Signature: \_\_\_\_\_

Date: \_\_\_/\_\_\_/\_\_\_

**Section 7: Prenatal History**

Child's birth was  At home  At a birthing center  At a hospital

Name of obstetrician / midwife / family physician: \_\_\_\_\_

Child's birth was  Natural vaginal (no medications/interventions)  Vaginal with intervention(s)  C-section

If intervention(s), what?  Induction  Pain medication  Epidural  Episiotomy

Vacuum extraction  Forceps  Other \_\_\_\_\_

If C-section, was it  Scheduled or  Emergency?

Please list reasons for any interventions/complications \_\_\_\_\_

Ultrasounds during pregnancy?  Yes  No If yes, how many and what was the medical reason? \_\_\_\_\_

Medications during pregnancy?  Yes  No If yes, what? \_\_\_\_\_

Cigarette use during pregnancy?  Yes  No Alcohol use during pregnancy?  Yes  No

Birth weight \_\_\_\_\_ Birth length \_\_\_\_\_ APGAR at birth \_\_\_\_\_ APGAR after 5 min. \_\_\_\_\_

**Section 8: Growth and Development**

Name of Pediatrician: \_\_\_\_\_ Date of last visit \_\_\_\_/\_\_\_\_/\_\_\_\_

Was your child alert and responsive within 12 hours of delivery?  Yes  No

If no, please explain \_\_\_\_\_

At what age did your child: Respond to sound \_\_\_\_\_ Follow an object \_\_\_\_\_ Hold head up \_\_\_\_\_

Teethe \_\_\_\_\_ Crawl \_\_\_\_\_ Walk \_\_\_\_\_ Vocalize \_\_\_\_\_

Is/was your child breastfed?  Yes  No If yes, how long? \_\_\_\_\_

Is/was your child fed formula?  Yes  No If yes, what type? \_\_\_\_\_

Introduction of cow's milk at age \_\_\_\_\_ Began solid foods at age \_\_\_\_\_

Please list any food(s)/juice(s) intolerance \_\_\_\_\_

Does your child eat well?  Yes  No Have regular bowel/bladder movements?  Yes  No

Has your child received any vaccinations?  Yes  No If yes, which ones and list any reaction(s) \_\_\_\_\_

Has your child received any antibiotics?  Yes  No If yes, how many times and for what reason? \_\_\_\_\_

Parent/Guardian's Signature: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

## Section 9: Goals For Your Child's Care

People see a chiropractor for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their body. Your doctor will weigh your child's needs and your desires when recommending his/her care program. Please check the type of care desired so that we may be guided by your wishes whenever possible. Thank you.

- I want the Doctor to select the type of care appropriate for my child's condition(s).
- Relief Care: Symptomatic relief of pain or discomfort
- Corrective Care: Correcting and relieving the cause of the problem as well as the symptom(s).
- Wellness Care: My child is healthy and I want to do whatever I can to keep him/her healthy.

## Section 10: Our Commitment to You and Your Child

We are committed to giving your child the best care possible in our office. If there is ever anything you wish to talk to the doctor about whether it be a question, concern or how we may better help you or your child, please let one of us know. We are here to serve you and your child and we thank you for the opportunity.

## Section 11: A Referral is the Greatest Compliment We Receive

Who may we thank for referring you to our office? \_\_\_\_\_

## Section 12: Preferred Contact Number and Time

Please indicate your preferred contact number and time of day. Thank you.

Preferred Contact Number: \_\_\_\_\_

Preferred Time: \_\_\_\_\_

Parent/Guardian's Signature: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_