Whole Health
CHIROPRACTIC

PEDIATRIC PATIENT INTRODUCTION

Child's Name: _____
Mother's Name: _____ Father's Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: (_____)_____ Mother's Work: (_____)_____ Mother's Cell: (_____)_____
Email: _____ Father's Work: (_____)_____ Father's Cell: (_____)_____

Birth Date: _____/_____ /_____ Age: _____ Sex: _____ # of Siblings: _____ Referred By: _____
Birth Weight: _____ Birth Length: _____ Current Weight: _____ Current Length: _____

Obstetrician/Midwife: _____
Pediatrician/Family MD: _____
Date of Last Visit: _____ Purpose: _____
Immunization History: _____
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: _____

Third Trimester Presentation: Vertex: _____ Breech: _____ Transverse: _____ Face/Brow: _____
Type of Birth: Vaginal: _____ Forceps: _____ Cesarean: _____ Suction/Vacuum: _____ Induced Labor: _____
Location: Home: _____ Birthing Center: _____ Hospital: _____ Duration of Gestation: _____
Problems during pregnancy: _____
Problems during labor/delivery: _____
Apgar Scores: _____ _____ Was there presence at birth of: Jaundice (yellow)? _____ Cyanosis (blue)? _____
Congenital anomalies/defect? _____ If yes, please explain? _____

Chemical Stressors

During pregnancy, did the mother (circle): **1. Smoke?** Yes No **2. Drink alcohol?** Yes No
3. Take supplements/vitamins? Yes No **4. Take drugs?** Yes No If yes, what? _____
5. Become ill? Yes No **6. Receive ultrasounds?** Yes No If yes, how many? _____
7. Receive an invasive procedure (amniocentesis, CVS)? Yes No If yes, please explain _____
Was your child breast fed (circle)? Yes No If yes, for how long? _____ weeks months years
At what **age** was: 1a. Formula introduced? _____ 1b. Brand? _____ 2. Cow's Milk? _____ 3. Solid Foods? _____
Did your child receive vaccinations? Yes No If yes, which ones? _____
Did your child react to them? Yes No If yes, how so? _____
Has your child had antibiotics? Yes No If yes, how many and why? _____
Any pets at home? Yes No Any smokers at home? Yes No If yes, how many? _____

Psychological Stressors

Any difficulties with lactation? Yes No Any problems bonding? Yes No
Does your child have any behavior problems? Yes No If yes, what? _____
Does your child have difficulties sleeping (e.g. night terrors, sleepwalking, etc.)? _____
Number of hours sleeping per night: _____ Quality of Sleep: Good _____ Fair _____ Poor _____
Did your child go to daycare? Yes No If yes, from what age? _____
Average number of hours in front of a TV/computer per week? _____

Traumatic Stressors

Any evidence of trauma at birth: Bruise ____ Odd shaped head ____ Stuck in birth canal ____ Fast/Long Birth ____
Respiratory ____ Depression ____ Cord around neck ____ Other: _____
Any falls/accidents during pregnancy? Yes No If yes, please explain? _____
Any hospitalizations? Yes No If yes, please explain? _____

Does your child play sports? Yes No # of hours per week? _____ Age child began? _____
Weight of school backpack? _____ lbs Approx. hours spent at play per week? _____ hrs

At what **age** did the child:

Respond to sound? _____ Follow an object with his/her eyes? _____ Hold head up? _____
Sit alone? _____ Crawl? _____ Stand? _____ Walk along? _____ Vocalize? _____

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
- ❑ Heart Trouble
- ❑ Chronic Earaches
- ❑ Sinus Trouble
- ❑ Asthma
- ❑ Colds/Flu
- ❑ Colic
- ❑ Orthopedic Problems
- ❑ Neck Problems
- ❑ Arm Problems
- ❑ Leg Problems
- ❑ Joint Problems
- ❑ Backaches
- ❑ Poor posture
- ❑ Scoliosis
- ❑ Walking Trouble
- ❑ Broken Bones
- ❑ Digestive Disorders
- ❑ Poor Appetite
- ❑ Stomach Aches
- ❑ Reflux
- ❑ Constipation
- ❑ Diarrhea
- ❑ Diabetes
- ❑ Hypertension
- ❑ Anemia
- ❑ Bed Wetting
- ❑ Behavioral Problems
- ❑ ADD/ADHD
- ❑ Ruptures/Hernia
- ❑ Muscle Pain
- ❑ Growing Pains
- ❑ Allergies to _____
- ❑ Allergies to _____
- ❑ Allergies to _____
- ❑ Other _____

Has this child ever suffered the following spinal traumas?

- ❑ Fall in baby walker
- ❑ Fall from crib
- ❑ Fall from highchair
- ❑ Fall from changing table
- ❑ Fall from bed/couch
- ❑ Fall off swing
- ❑ Fall off slide
- ❑ Fall off monkey bars
- ❑ Fall off skateboard or skates
- ❑ Fall off bicycle
- ❑ Fall down stairs
- ❑ Other _____

Do the child's siblings have any health problems? Yes No If yes, please explain? _____

AUTHORIZATION FOR CARE OF MINOR

I hereby authorize this office and its doctor(s) to administer care as they so deem necessary for 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. I understand that X-rays remain the property of this office.

SIGNED: _____ DATE: _____/_____/_____

Insurance/Billing information: _____ Policy #: _____