

Parent's Last Name:	
Child's First Name:	

PERSONAL INFORMATION

Child's Name: First:		Last:		Middle Initial:	
Mother's Name:			Mother's DOB:		
Father's Name:			Father's DOB:		
Address:			City:		
State:	Zip:	Home Phone: ()			
Mother's Work Phone: ()		Mother's Cell : ()			
Father's Work Phone: ()		Father's Cell : ()			
EMAIL :		Fax: ()			
Child's birth date: Month:		Day:	Year:	Child's Sex (Circle One): Male/Female	
Birth Weight:	Birth Length:	Current Weight:	Current Length:		
Referred by:					
Siblings: Name:		Sex: (Circle One)		Birth Date:	
		Male/Female		Month:	Day: Year:
		Male/Female		Month:	Day: Year:
		Male/Female		Month:	Day: Year:
Third Trimester Presentation: Vertex: Breech: Tansverse: 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:					
# of doses of antibiotics your child has taken: During past 6 months: During lifetime:					
Previous chiropractor:					
Date of Last Visit:		Purpose:			
Has your child ever been treated on an emergency basis? If yes, please explain					
Present history:					
Purpose of this appointment:					

Parent's Last Name: _____
Child's First Name: _____

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 the 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 | <input type="checkbox"/> Leg Problems | <input type="checkbox"/> Reflux | <input type="checkbox"/> Muscle Pain |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Joint Problems | <input type="checkbox"/> Constipation | <input type="checkbox"/> Growing Pains |
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Backaches | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Allergies to |
| <input type="checkbox"/> Chronic Earaches | <input type="checkbox"/> Poor Posture | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Allergies to |
| <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Allergies to |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Walking Trouble | <input type="checkbox"/> Anemia | <input type="checkbox"/> Other |
| <input type="checkbox"/> Colds/Flu | <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Bed Wetting | |
| <input type="checkbox"/> Colic | | | |

- 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 ye, please explain

Has this child ever sustained injuries in an auto accident? If yes, please explain

Surgery:

Medications:

Accidents:

Family History:

AUTHORIZATION FOR CARE OF MINOR

I hereby authorize this office and it's 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:** _____