# Pediatric Patient Introduction

Child's Name: _____
LAST FIRST MIDDLE

Mother's/Guardian Name: _____
LAST FIRST MIDDLE

Father's Name: _____
LAST FIRST MIDDLE

Address: _____ City: _____ State: _____

Home Phone: (____)-_____-_____ Mother's work: (____)-____-_____ Father's work: (___)-____-_____

Birth Date: _____ Age: _____ Birth Weight: _____ Current Weight: _____

Sex: M / F Number of Siblings: ____ Birth Length: _____ Current Length: _____

Type of Birth: __ Normal Vaginal __ Forceps __ Cesarean __ Breech
__ Hospital __ Home __ Birthing Center

Problems During Pregnancy: _____

Problems During Labor/Delivery: _____

Infant Feeding: __ Breast __ Bottle __ Formula
Hours of Sleep Per Night: _____ Quality of Sleep: __ Good __ Fair __ Poor

Pediatrician/Family MD: _____
NAME ADDRESS

Immunization History: _____

Purpose of This Appointment: _____

Has Your Child Been treated On an Emergency Basis?: _____
Describe: _____

**AUTHORIZATION TO CARE FOR MINOR**

I Hereby Authorize This Clinic To Administer Care As They So Deem Necessary For The Benefits Of My Son / Daughter.

Signed: _____ Witnessed: _____ Date: _____

I Realize That I Am Responsible For All Fees Charged By This Clinic And I Will Pay For All Services As They Are Performed. X-Rays will Remain The Property Of This Clinic.

Date: _____ Signature: _____

**DENN CHIROPRACTIC LLC 475 CHIPPEWA MALL DR SUITE 155 CHIPPEWA FALLS, WI (715) 726-0400**