Rockwall Health Center
2880 Ridge Rd
Rockwall, TX 75032
(469) 769-1009

PEDIATRIC PATIENT HEALTH RECORD

CHILD'S NAME:	
MOTHER'S NAME:	DOB:
FATHER'S NAME:	DOB:
ADDRESS:	
CITY:	STATE/ZIP:
HOME PHONE:	EMAIL:
MOTHER'S WORK PHONE:	MOTHER'S CELL:
FATHER'S WORK PHONE:	FATHER'S CELL:

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 VAGINA:	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:	
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:	

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 THIS CHILD SUFFER FROM THE FOLLOWING CHILDHOOD DISEASES? CHICKENPOX:	MUMPS:	MEASLES:	
RUBEOLA:	WHOOPING COUGH:	RUBELLA:	OTHER:

HAS THIS CHILD EVER SUFFERED FROM?

☐ HEADACHES	☐ ORTHOPEDIC PROBLEMS	☐ DIGESTIVE DISORDERS
☐ DIZZINESS	☐ BEHAVIORAL PROBLEMS	☐ NECK PROBLEMS
☐ POOR APPETITE	☐ ADD/ADHD	☐ FAINTING
☐ ARM PROBLEMS	☐ REFLUX	☐ MUSCLE PAIN
☐ STOMACH ACHES	☐ RUPTURES/HERNIA	☐ SEIZURES/CONVULSIONS
☐ LEG PROBLEMS	☐ HEART TROUBLE	☐ JOINT PROBLEMS
☐ CONSTIPATION	☐ GROWING PAINS	☐ CHRONIC EARACHES
☐ BACKACHES	☐ DIARRHEA	☐ SINUS TROUBLE
☐ POOR POSTURE	☐ DIABETES	☐ HYPERTENTION
☐ SCOLIOSIS	☐ ASTHMA	☐ COLDS/FLU
☐ COLIC	☐ WALKING TROUBLE	☐ ANEMIA
☐ BROKEN BONES	☐ BED WETTING	☐ OTHER
☐ ALLERGIES:		

HAS THIS CHILD EVER SUFFERED THE FOLLOWING SPINAL TRAUMAS?

☐ FALL IN BABY WALKER	☐ FALL FROM BED/COUCH	☐ FALL OFF SKATEBOARD/SKATE
☐ FALL FROM CRIB	☐ FALL OFF SWING	☐ FALL OFF BICYCLE
☐ FALL FORM 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?

☐ YES ☐ NO

IF YES, PLEASE EXPLAIN:

HAS THIS CHILD EVER SUSTAINED INJURIES IN AN AUTO ACCIDENT?

☐ YES ☐ NO

IF YES, PLEASE EXPLAIN:

PRESENT HISTORY:

SURGERY:

MEDICATIONS:

ACCIDENTS:

FAMILY HISTORY:

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. 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 PROPERTY OF THIS OFFICE.

SIGNED: _____ DATE: _____