South Trail Chiropractic
Family Wellness Centre

Dr. Jeffrey P. Koep

Confidential Pediatric Patient Information

Child's Name _____

Address: _____ City _____

Province _____ Postal Code _____

Phone (h) _____ (w) _____

Birth Date: _____ AHC #: _____

Sex: _____ Weight: _____ Height: _____

Referred by: _____

Name of Parents/Guardians: _____

Purpose of visit? _____

Other doctors seen for this condition ☐ Yes ☐ No
If yes, Doctors' Names and Prior Treatments_____

Other health problems? _____

Check any of the following conditions your child has suffered from during the last six months:

☐ ear infections	☐ bed wetting	☐ recurring fevers
☐ asthma/allergies	☐ seizures	☐ temper tantrums
☐ colic	☐ ADHD	☐ headaches
☐ scoliosis	☐ car accident	☐ growing/back pains
☐ digestive problems	☐ chronic colds	☐ other _____

Family history _____

Previous chiropractor _____
Date of last visit _____ Reason _____

Name of Pediatrician: _____
Date of last visit _____ Reason _____
Are you satisfied with the care your child has received there? ☐ Yes ☐ No

Number of doses of Antibiotics your child has taken: _____
During the last six months: _____, Total during his/her lifetime: _____

Number of doses of other prescription medicines your child has taken: _____
During the last six months: _____, Total during his/her lifetime: _____List:_____

Vaccination history: _____

PRENATAL HISTORY

Name of Obstetrician/Midwife:_____

Complications during pregnancy? ☐ Yes ☐ No, List: _____
Ultrasounds during pregnancy? ☐ Yes ☐ No, Number: _____
Medications during pregnancy? ☐ Yes ☐ No, List:_____

Cigarette/alcohol use during pregnancy? ☐ Yes ☐ No
Location of birth: ☐ Hospital ☐ Birth Centre ☐ Home

Birth intervention: ☐ Forceps ☐ Vacuum extraction ☐ C Section (emergency or planned)
Complications during delivery? ☐ Yes ☐ No, List: _____
Genetic Disorders or disabilities? ☐ Yes ☐ No, List: _____
Birth Weight: _____ Birth Length: _____ APGAR Scores _____, _____

FEEDING HISTORY

Breast Fed: ☐ Yes ☐ No, How long: _____
Formula Fed: ☐ Yes ☐ No, How long: _____, Type: _____
Introduced to solids at: _____ months, Cow's milk at: _____ months
Food/Juice allergies or intolerances: ☐ Yes ☐ No, List: _____

DEVELOPMENTAL HISTORY

During the following times, your child's spine is most vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference). At what age was your child able to:

_____ respond to sound
_____ respond to visual stimuli
_____ hold head up
_____ sit up
_____cross crawl
_____ stand alone
_____ walk alone

According to the National Safety Council, approximately 50% of children fall head first from a high place during the first year of life (i.e. a bed, hanging table, down stairs. etc.). Was this the case with your child?
☐ Yes ☐ No

Is/has your child been involved in any high impact or contact type sports (i.e. soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.)? ☐ Yes ☐ No, List _____

Has your child ever been involved in a car accident ☐ Yes ☐ No, List _____
Has your child been seen on an emergency basis ☐ Yes ☐ No, List _____
Other traumas not described above? _____
Prior surgery ☐ Yes ☐ No, List _____
Menarche: ☐ Yes ☐ No, Age

Childhood diseases:

☐ chicken pox, age ____
☐ rubella, age ____
☐ rubeola, age ____
☐ mumps, age ____
☐ whooping cough, age ____
☐ other _____, age ____

AUTHORIZATION FOR CARE OF MINOR

I hereby authorize this office and its Doctor to administer care to my son/daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Signature _____ Date _____