CONFIDENTIAL PATIENT INFORMATION - PEDIATRIC

Personal Information **Date:**

Full name : First / Middle / Last	**Preferred Name (optional):** Preferred Pronouns(optional):
Parent/Guardian name(s):	
Address: Street / City / State / Zip	
Home phone (optional):	**Email:**
Cell phone:	
Preferred Contact: Call Home □ Call Cell □ Text □ Email □	**Preferred time for calls/texts:**
Date of birth:	**Age:**
Height:	**Weight:**
Do you have a HSA or FLEX Card? Yes □ No □	
How did you hear about our office?	

Check this box to give Body Wave permission to send SMS text messages

☐ YES, I would like to receive SMS text notifications from Body Wave (Text STOP to cancel at any time)

☐ NO, I would not like to receive SMS text notifications from Body Wave.

Date:_____ **Initials:**_____

Addressing What Brought You Into This Office:

Health Concerns

Please list health concerns according to their severity	When did this start?	Did the problem begin with an injury?
1.		
2.		
3.		

Other Doctors seen for these conditions? **Yes** □ **No** □ If yes, _____

Prior Treatments: _____

Is your child taking any prescription medication? **Yes** □ **No** □ If so, how many _____

Has your child taken antibiotics **Yes** □ **No** □ If so, what is the total amount of doses administered? _____

What activities would your child like to do that their health is preventing?

_____

_____

_____

Past Health History

Please circle the following conditions your child has experienced (if applicable):

Ear Infections	Allergies	Asthma	Scoliosis	Colic	Digestive Issues
Frequent Colds	Headaches	ADHD	Recurring Fevers	Growing/Back Pains	Bed wetting
Car Accidents	Temper Tantrums	Skin Problems	Sleep Issues	Chronic Fatigue	Other

Other (please explain) _____

_____

Developmental History
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 their first year of life (i.e a bed, changing table, chair, downstairs, etc.). Was this the case with your child? **Yes** □ **No** □

If yes, list when and type of fall: _____

Is/has your child been involved in any high impact or contact type of sport? (i.e. soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.)? **Yes** □ **No** □

If yes, type(s): _____

Has your child ever been involved in a car accident? **Yes** □ **No** □

If yes, when: _____

Other Traumas not described above? **Yes** □ **No** □

_____

_____

Prenatal History
What there a birth intervention? **Yes** □ **No** □ If, yes please select intervention type:

Caesarian Emergency	Caesarian Planned	Forceps	Vacuum Extraction

Were there complications during delivery? **Yes** □ **No** □ If so, please list:

_____

_____

Is there anything else which may help to better understand you which has not been discussed?

_____

_____

_____

_____

_____