Taylor Family chiropractic™

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PEDIATRIC PATIENT INTRODUCTION CARD

Child's Name: _____ Age: _____ Date of Birth: _____ Sex: M F

Street Address: _____ City, ST, Zip: _____

Parent's Names: _____

Phone: _____ Email: _____

Whom may we thank for referring you to our office? _____

Reason for coming to our office: _____

Name of Person Responsible for the Account: _____

Relationship to Patient: _____ Preferred Phone #: _____

Address (if different than above): _____

Insurance Company: _____ Name of Insured: _____

Relationship to Patient: _____ Date of Birth: _____

PRESENT HEALTH CHALLENGE(S)

For what health challenge(s) is your child here for? When did it begin? _____

_____

Has your child seen other health care practitioners for this? What did they recommend? _____

_____

What was the outcome of prior treatment/recommendations? _____

_____

Is this dysfunction getting progressively worse? _____ Yes _____ No

HEALTH HISTORY

Symptoms: Please check any current or past problems you child has on the list below:

_____Anemia
_____Arthritis
_____ADHD
_____Allergies
_____Anxiety
_____Arm/Elbow Pain
_____Asthma
_____Autism
_____Backaches
_____Behavioral Issues
_____Bed Wetting
_____Blood Disorders
_____Broken Bones: _____
_____Chest Pain
_____Chronic Earaches
_____Colic
_____Concussions
_____Constipation
_____Convulsions
_____Cough/Wheeze
_____Diabetes
_____Diarrhea
_____Digestive Problems
_____Dizziness
_____Eczema
_____Fainting
_____Fever/Chills
_____Frequent Colds
_____Growing Pains
_____Headaches
_____Heart Condidtion
_____Hernias
_____Hyperactivity
_____Hypertension
_____Joint Pain
_____Insomnia
_____Itchy Eyes
_____Knee/Foot Pain
_____Leg/Hip Pain
_____Muscle Pain
_____Neck Pain
_____Nightmares
_____Poor Appetite
_____Poor Memory
_____Rashes
_____Reflux/Spitting Up
_____Runny Nose
_____Scoliosis
_____Sinus Trouble
_____Sprains/Strains
_____Stomach Aches
_____Unusual Moles
_____Other _____

Name of Pediatrician: _____ Date of Last Visit: _____

Current Medications / Vitamins: _____

Past Trauma (falls, sports injuries, accidents, etc): _____

Past Surgeries: _____

PRENATAL HISTORY

Location of Birth: ___Home ___Birthing Center ___Hospital

Complications during pregnancy: ❑ No ❑ Yes, List: _____

Medications during pregnancy/delivery: _____

Cigarette/Alcohol use during pregnancy: ❑ No ❑ Yes

Birth intervention: ____Forceps ____Vacuum ____Caesarian

Complications during delivery: ❑ No ❑ Yes, List: _____

Birth weight: _____ Birth length: _____

FEEDING HISTORY

Breast Fed: ❑ No ❑ Yes, How long? _____

Formula Fed: ❑ No ❑ Yes, How long? _____ Type: _____

Introduced to cereal at _____ months. Solids at _____ months. Cow's milk at _____ months.

Food / juice allergies or intolerances: ❑ No ❑ Yes, List: _____

DEVELOPMENTAL HISTORY

Sleep (hours per night)_____ Problems sleeping _____

MEDICAL / VACCINATION HISTORY

Has your child ever had an adverse reaction to a prescription or over-the-counter medication? ❑ No ❑ Yes

If yes, please explain: _____

Has your child been vaccinated? ❑ No ❑ Yes, adverse reactions to any vaccine? _____

CHILDHOOD DISEASES

❑ Chicken Pox: Age _____ ❑ Mumps: Age _____ ❑ Rubella: Age _____

❑ Whooping Caugh: Age _____ ❑ Measles: Age _____ ❑ Meningitas: Age _____

❑ Tuberculosis: Age _____ ❑ Other: Age _____

CONSENT FOR TREATMENT OF MINOR

I hereby certify that the information I have provided is correct and accurate, to the best of my knowledge.

I, _____, as the parent/guardian of this child, _____, hereby grant permission for my child to receive examination and chiropractic treatment as deemed necessary.

_____ _____

Signature of Parent or Guardian Date