Pediatric Patient Introduction

Child's Name:________________________ Mothers Name:__________________ DOB:___________
Father's Name:_______________________ DOB:___ __________
Address:____________________ City/Town:___________________ State:______ ZIP:__________
Mothers Phone Number:____-____-______ Fathers Phone Number: ____-____-______
Email:____

Birth Date:______________ Age: _________ Sex: ________ Number of Siblings: ______
Referred By: ______________ Birth Weight: ______________ Birth Length: ______________
Current Weight: ______________ Current Length: ______________

Third Trimester Presentation ☐Vertex (Head Down) ☐Breech ☐Transverse (Sideways) ☐Face/Brow
Type of Birth: ☐Normal Vaginal ☐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)? ☐Yes ☐No
Cyanosis (Blue)? ☐Yes ☐No Congenital Anomalies/Defects? ☐Yes ☐No
If Yes, Please Explain____

Infant Feeding: ☐Breast ☐Bottle If Bottle, Which Formula? ______________________
Hours of Sleep Per Night: ______________ Quality of Sleep (circle): Good Fair Poor

Obstetrician/Midwife: ____
Pediatrician/Family MD: ____
Date of Last Visit: ______________ Purpose: _______________________________________
Immunization History: ____
Previous Chiropractor: ____
Date of Last visit: ______________ Purpose: ____
Has your child ever been treated on an emergency basis? ☐Yes ☐No If yes, please explain:
____

Purpose of this appointment:
____
____

Delivery/ Birth History:
____
____
____
____

At what age did the Child:

Respond to Sound: ________ Follow an object with their eyes: ________ Hold Head Up: ________
Sit Alone: ________ Crawl: ________ Stand: ________ Walk alone: ________

At what age, if ever, did the child suffer from the following childhood diseases?

Chicken Pox: ________ Mumps: ________ Measles: ________ Rubella: ________
Rubeola: ________ Whooping Cough: ________ Other: ______________________

Has this child ever suffered from:

- ☐ Headaches
- ☐ Dizziness
- ☐ Fainting
- ☐ Seizures/Convulsions
- ☐ Heart Trouble
- ☐ Chronic Earaches
- ☐ Sinus Trouble
- ☐ Asthma
- ☐ Colds/Flu
- ☐ Colic
- ☐ Orthopedic Problems
- ☐ Neck Problems
- ☐ Arm Problems
- ☐ Leg Problems
- ☐ Joint Problems
- ☐ Backaches
- ☐ Poor Posture
- ☐ Scoliosis
- ☐ Walking Trouble
- ☐ Broken Bones
- ☐ Digestive Disorders
- ☐ Poor Appetite
- ☐ Stomach Aches
- ☐ Reflux
- ☐ Constipation
- ☐ Diarrhea
- ☐ Diabetes
- ☐ Hypertension
- ☐ Amenia
- ☐ Bed Wetting
- ☐ Behavioral Problems
- ☐ ADD/ADHD
- ☐ Ruptures/Hernia
- ☐ Muscle Pain
- ☐ Growing Pains
- ☐ Allergies to________
- ☐ Allergies to________
- ☐ Other____________
- ☐ Other____________

Has this child ever suffered the following spinal trauma?

- ☐ Fall in Baby Walker
- ☐ Fall from Crib
- ☐ Fall from Highchair
- ☐ Fall from Changing Table
- ☐ Fall from Bed or Couch
- ☐ Fall off Swing
- ☐ Fall off Slide
- ☐ Fall off Monkey Bars
- ☐ Fall off Skateboard or Skates
- ☐ Fall off Bicycle
- ☐ Fall down Stairs

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:____

Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may effect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care, we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

______________________________ ________________________________ ______________

Print Name Signature Date

Consent to evaluate and adjust a minor child:

I, ________________________ being the parent or legal guardian of ___________________________ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release:

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: ________________________________

____ ______________________

Signature Date