PEDIATRIC NEW PATIENT INFORMATION

PERSONAL HISTORY

Patient Name:____ Date:_______________

Parent/Guardian Name:____

Care Card #:___________________ Phone #:________________ Work #:____________

Address: ____ Postal Code: __________

Age: ________ Weight: _____________ Height: ____________

Birthday: _____________________ Birthplace: ________________________________

Family MD/Pediatrician: ____

Referred to this office by: ____

CURRENT HEALTH CONDITION

Present Complaint: ____

Previous Treatment: ____

When did it begin? ____

Are there others in your family with this same condition? Or spinal conditions? ________

What do you believe caused this condition? ____________________________________

Is your child presently taking any medications? _________________________________

List any activities/sports your child participates in: ______________________________

PAST HEALTH HISTORY

Major Surgery? Operations:________________ Appendix____ Tonsils____ Hernia____
Tubes in Ears____ Other___________________________
Problems during Pregnancy or Labor delivery: __________________________________
Type of Birth: ____
At Birth, was there presence of: Jaundice (yellow)_____ Cyanosis (blue) _____
Congenital Anomalies/defects: ____
Infant Feeding: Breast_____ Bottle_____ Formula_____ Solid Foods _____

Childhood Diseases: Chicken pox _______ German Measles________

Mumps___________ Whooping Cough_______

Measles___________ Other Disease__________________

Developmental History: At what age did the child…..

Respond to sound ________________ Hold head up_________________

Follow an object with the eye____________________

Sit alone__________________ Crawl__________________________

Stand____________________ Walk alone___________________

Has your child been treated on an emergency basis? Yes_____ No_____

Major Accidents or Falls, Fractures (please describe)_____________________________

____

Previous Chiropractic Care and approximately date of last visit____________________

Treatment for any health condition in the last year: Yes_____ No_____

If yes, please explain:____

Please check any of the following conditions that are a problem and underline any that where a problem in the past.

___ SORE MUSCLES
___ PAINFULL/STIFF JOINTS
___ GROWING PAINS
___ MUSCLE CRAMPS
___ LOW BACK PROBLEMS
___ BEHAVIOR PROBLEMS
___ FREQUENT COLDS/FLUS
___ EPILEPSY
___ STOMACH ACHES
___ DIFFICULT CHEWING/CLICKING JAW
___ RHEUMATIC FEVER
___ CONSTIPATION/DIARRHEA
___ POOR/EXCESSIVE APPETITE
___ JUNK FOOD
___ COORDINATION PROBLEMS
___ HEADACHES
___ SKIN ERUPTIONS/ECZEMA

___ FATIGUE
___ ALLERGIES
___ DIFFICULTIES SLEEPING
___ DIZZINESS
___ FAINTING
___ NECK PROBLEMS
___ PAIN BETWEEN SHOULDERS
___ SPINAL CURVATURE
___ ARTHRITIS
___ DIABETES
___ BEDWETTING
___ WALKING PROBLEMS
___ ANEMIA
___ NERVOUSNESS
___ THYROID PROBLEMS
___ DEPRESSION/ANXIETY

___ VISION PROBLEMS
___ DENTAL PROBLMES
___ HEARING PROBLMES
___ HYPERACTIVITY

___ EARACHES
___ NOSE BLEEDING
___ ASTHMA
___ PERSISTANT COUGH

___ WEIGHT TROUBLE

___ FEET TURN IN/OUT
___ VOMITING
___ SORE THROAT