Chiropractic Pediatric Patient Information

Date:______/____/_______ Patient#___________ **Doctor:_________________________________**

Name:___________________________ Social Security #________________Home Phone: __________________
Address:_____________________________________City:____________________ State:_____ Zip:___________
Age:_______ Gender: □M □F Birth Date:_____/______/_______ Home phone: _____________________
Parent/Guardian_____________________________________ Cell/work Phone:____________________________
Parent/Guardian_____________________________________ Cell/work Phone:____________________________
E-mail address:____ May we contact you via text msg? □Yes □No
Who referred you to our office (how did you find us)? ____

Please check any and all insurance coverage that may be applicable in this case**:**
□ Major Medical Insurance **□Medical Savings Account & Flex Plans** **□Worker's Compensation**
□ Medical Assistance **□Medicare** **□Auto Accident** **□ Itasca Health Care (IMC)**
□Other____________________
Name of Primary Insurance Company:____
Name of Secondary Insurance Company (if any):____

Prenatal/Birth History
Number of Siblings_____________ Birth Weight_____________ Current Weight _____________
At time of birth child was: [ ]Head down [ ]Breech [ ]Transverse [ ]Face forward
Type of birth: [ ]Normal Vaginal [ ]Forceps [ ]Cesarean [ ]Suction/vacuum
Location: [ ]Home [ ]Birthing center [ ] Hospital
Problems during pregnancy: (ex: diabetes, blood pressure)____
Ultrasounds during pregnancy: #_______ Cigarette use during pregnancy? □ Yes □No Alcohol use? □ Yes □No
Medications taken/vaccines received during pregnancy: ____
Problems during delivery/labor: ____
APGAR Scores: _____/ ______ Was there presence at birth of: [ ]Jaundice(yellow) [ ]Cyanosis(blue)
[ ]Congenital abnormalities/defects, if yes, please explain____
OB/Midwife:______________________________ Pediatrician/Family MD:__________________________________
Date of last visit: _____________________ Purpose of visit:____
Immunization history:____
Number of doses of antibiotics your child has taken: In past 6 months:___________ In his/her lifetime:________
Previous Chiropractor:_________________________________ Date of last visit:_____________________________
When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? □ Yes □No

CHIEF COMPLAINT
Chief Complaint: (Purpose of this appointment): ____
Date symptoms appeared or accident happened:____
Have you ever had the same or a similar condition? □ Yes □ No If yes, when & how it started:_____________
____

Today, is there pain? (no pain) 0 1 2 3 4 5 6 7 8 9 10 (extreme pain). On average: _____/10

Are you experiencing any of these types of pain? [ ]Aching [ ]Burning [ ]Stabbing [ ]Shooting [ ]Dull [ ]Tingling

Have you had any X-rays or MRI's taken of this area? □ Yes □ No If yes, when _________________________

REVIEW OF SYSTEMS/Development

At what age did your child: Respond to sound:___________ Follow objects with his/her eyes:____________
Hold up head: _____________ Sit alone:______________ Crawl:_____________ Stand:_______________
Walk alone:________________ At what age, if ever, has this child suffered from the following childhood diseases: Chickenpox:__________ Mumps:____________ Measels:__________ Rubella:__________
Rubeola:_________ Whooping Cough:___________ Other:____

Has this child ever suffered from?

□Headaches
□Dizziness
□Fainting
□Seizures
□Heart trouble
□Chronic earaches
□Sinus trouble
□Asthma
□Allergies
□Colds/Flus
□Colic

□Orthopedic problems
□Neck problems
□Arm problems
□Leg problems
□Joint problems
□Flattened skull
□Backaches
□Growing pains
□Poor posture
□Scoliosis

□Walking trouble
□Broken Bones
□Digestive disorders
□Poor appetite
□Stomach aches
□Reflux
□Constipation
□Diarrhea
□Diabetes
□Hypertension
□Anemia

□Bed wetting
□Behavioral problems
□Temper tantrums
□ADD/ADHD
□Hernias
□Muscle pains
□Bruises easily
□Failure to thrive
Other___________
____

Has the child ever suffered from the following spinal traumas?

□Fall in baby walker
□Fall from crib
□Fall from highchair
□Fall down stairs

□Fall from changing table
□Fall from bed or couch
□Fall off swing

□Fall off slide
□Fall of monkey bars
□Fall off skateboard or rollerblades

□Fall off bicycle
□Other__________
____

Describe any type of exercising/sports the child does:____
Do you exercise as above □ Regulary (4+week) □ Occasionally (1-2x/week) □ Rarely
Has the child ever sustained an injury while playing sports? ____
Any automobile accidents (even at low speed)? ____

Has the child had any other emergency care, major illnesses, injuries, falls, or surgeries? __________________
____
Any medications or drugs taken in the last 2yrs (and what for?)____
____
Any vitamins/supplements:____
Any allergies to any medications? □ Yes □No If yes, describe:_______________________________________

LIFESTYLE HABITS

Was the child breast fed? □ Yes □No If yes, how long:____
Any allergies to any foods? □ Yes □No If yes, describe:_________________________________
Females: Date of your last menstrual period, if any _______________ How old when first got period_____

How many hours per night do you sleep? __________ Any naps? ___________________
Have trouble sleeping: □Every night □ Few times/week □ Few times/month □ Rarely
Soda pop per week: _____________________ Caffeine per week:_________________
Servings of dairy ____________/ day Fast food meals per week __________________
Serving Fruits and Vegetables______________/day
Do you have any known or suspected food sensitivities? ____

FAMILY HISTORY

Does the child have any relatives with: (write in relation)

Arthritis _______________
Back trouble____________
Disc problems___________
Sciatica________________
Poor posture____________
Scoliosis________________
Cancer_________________
Diabetes (type 1)_________
Diabetes (type 2)_________
Heart disease_______________

Heart valve problems________
Kidney problems____________
Insomnia__________________
Emphysema________________
High Blood pressure_________
Migraines_________________
Other headaches____________
Depression_________________
Anxiety________________
Asthma _______________

Allergies_______________
Sinusitis________________
Autism/ASD_____________
Sensory issues__________
ADD/ADHD_____________
Ear infections___________
Eczema________________
IBS____________________
Gluten intolerance_______
Constipation____________

Print Name of Patient ________________________________ Date __________________________

Signature of Patient/Legal Guardian ____