

PEDIATRIC PATIENT INTRODUCTION

Child's name: \_\_\_\_\_ Mother's name: \_\_\_\_\_ DOB: \_\_\_\_\_

Case Number: \_\_\_\_\_ Father's name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ City/Town: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Mother's Work Phone: \_\_\_\_\_ Mother's Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_ Father's Work Phone: \_\_\_\_\_ Father's Cell Phone: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ # of Siblings: \_\_\_\_\_ Referred By: \_\_\_\_\_

Birth Weight: \_\_\_\_\_ Birth Length: \_\_\_\_\_ Current Weight: \_\_\_\_\_ Current Length: \_\_\_\_\_

3<sup>RD</sup> Trimester Presentation: Vertex \_\_\_\_\_ Breech \_\_\_\_\_ Transverse \_\_\_\_\_ Face/Brow \_\_\_\_\_

Type of Birth: Normal Vaginal \_\_\_\_\_ Forceps \_\_\_\_\_ Cesarean \_\_\_\_\_ Suction Cup or Vacuum \_\_\_\_\_

Location: Home \_\_\_\_\_ Birthing Center \_\_\_\_\_ Hospital \_\_\_\_\_

Problems During Pregnancy: \_\_\_\_\_

Problems during Labor/Delivery: \_\_\_\_\_

Apgar Scored: \_\_\_\_\_ Was there presence at birth: Jaundice (Yellow) \_\_\_\_\_ Cyanosis(Blue) \_\_\_\_\_

Congenital Anomalies/Defects? \_\_\_\_\_ If yes, Please Explain? \_\_\_\_\_

Infant Feeding: Breast \_\_\_\_\_ Bottle \_\_\_\_\_ If Bottle, Which Formula \_\_\_\_\_

Number of Hours of Sleep per Night: \_\_\_\_\_ Quality of Sleep: Good \_\_\_\_\_ Fair \_\_\_\_\_ Bad \_\_\_\_\_

Obstetrician/Midwife: \_\_\_\_\_

Pediatrician/Family MD: \_\_\_\_\_

Date of Last Visit: \_\_\_\_\_ Purpose: \_\_\_\_\_

Immunization History: \_\_\_\_\_

Number of Doses of Antibiotics your child has taken: During Past 6 month's \_\_\_\_\_ Lifetime \_\_\_\_\_

Previous Chiropractor: \_\_\_\_\_

Date of Last Visit: \_\_\_\_\_ Purpose: \_\_\_\_\_

Has your child ever been treated on an emergency basis? \_\_\_\_\_ If yes, Please Explain: \_\_\_\_\_

Purpose of this Appointment: \_\_\_\_\_

Insurance/Billing Information: \_\_\_\_\_ Policy #: \_\_\_\_\_

AUTHORIZATION FOR CARE OF MINOR

I hereby authorize Slak Chiropractic Group and its doctors to administer care as they deem necessary to my Son/Daughter/Ward (upon approval of parent/guardian)

SIGNED: \_\_\_\_\_ WITNESSED: \_\_\_\_\_ DATE: \_\_\_\_\_

I understand I am responsible for all fees charged by this office and agree to pay for services rendered. X-rays remain the property of Slak Chiropractic Group.

SIGNED: \_\_\_\_\_ DATE: \_\_\_\_\_

# PEDIATRIC CASE HISTORY

Delivery/Birth History: \_\_\_\_\_

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At what age did the child:

Respond to Sound \_\_\_\_\_ Follow an object with his/her eyes \_\_\_\_\_ Hold head up \_\_\_\_\_

Sit alone \_\_\_\_\_ Crawl \_\_\_\_\_ Stand \_\_\_\_\_ Walk Alone \_\_\_\_\_

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

Chickenpox \_\_\_\_\_ Mumps \_\_\_\_\_ Measles \_\_\_\_\_ Rubella \_\_\_\_\_

Rubeola \_\_\_\_\_ Whooping Cough \_\_\_\_\_ Other \_\_\_\_\_

Has this child ever suffered from:

- |                                                   |                                              |                                             |                                              |
|---------------------------------------------------|----------------------------------------------|---------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Headaches                | <input type="checkbox"/> Orthopedic Problems | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Behavioral Problems |
| <input type="checkbox"/> Dizziness                | <input type="checkbox"/> Neck Problems       | <input type="checkbox"/> Poor Appetite      | <input type="checkbox"/> ADD/ADHD            |
| <input type="checkbox"/> Fainting                 | <input type="checkbox"/> Arm Problems        | <input type="checkbox"/> Stomach Aches      | <input type="checkbox"/> Ruptures/Hernia     |
| <input type="checkbox"/> Seizures/<br>Convulsions | <input type="checkbox"/> Leg Problems        | <input type="checkbox"/> Reflux             | <input type="checkbox"/> Muscle Pain         |
| <input type="checkbox"/> Heart Trouble            | <input type="checkbox"/> Joint Problems      | <input type="checkbox"/> Constipation       | <input type="checkbox"/> Growing Pains       |
| <input type="checkbox"/> Chronic Earaches         | <input type="checkbox"/> Backaches           | <input type="checkbox"/> Diarrhea           | <input type="checkbox"/> Broken Bones        |
| <input type="checkbox"/> Sinus Trouble            | <input type="checkbox"/> Poor Posture        | <input type="checkbox"/> Diabetes           | <input type="checkbox"/> Allergies to _____  |
| <input type="checkbox"/> Asthma                   | <input type="checkbox"/> Scoliosis           | <input type="checkbox"/> Hypertension       | <input type="checkbox"/> Allergies to _____  |
| <input type="checkbox"/> Colds/Flu                | <input type="checkbox"/> Walking Trouble     | <input type="checkbox"/> Anemia             | <input type="checkbox"/> Other _____         |
|                                                   | <input type="checkbox"/> Colic               | <input type="checkbox"/> Bed Wetting        | <input type="checkbox"/> Other _____         |

Has this child ever suffered the following spinal traumas?

- |                                                   |                                                 |                                                        |
|---------------------------------------------------|-------------------------------------------------|--------------------------------------------------------|
| <input type="checkbox"/> Fall in baby walker      | <input type="checkbox"/> Fall from bed or couch | <input type="checkbox"/> Fall off skateboard or skates |
| <input type="checkbox"/> Fall from crib           | <input type="checkbox"/> Fall off swing         | <input type="checkbox"/> Fall off bicycle              |
| <input type="checkbox"/> Fall from highchair      | <input type="checkbox"/> Fall off slide         | <input type="checkbox"/> Fall down stairs              |
| <input type="checkbox"/> Fall from changing table | <input type="checkbox"/> Fall off monkey bars   | <input type="checkbox"/> Other _____                   |

Has this child ever sustained an injury playing organized sports? \_\_\_\_\_ If yes, Please explain: \_\_\_\_\_

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Has this child ever sustained injuries in an automobile accident? \_\_\_\_\_ If yes, Please explain: \_\_\_\_\_

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Present History: \_\_\_\_\_

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Surgery: \_\_\_\_\_

Medications: \_\_\_\_\_ Accidents: \_\_\_\_\_

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FamilyHistory: \_\_\_\_\_

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