CORRECTIVE CARE CHIROPRACTIC

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Pediatric Patient Information

Today's Date _____ File No. _____

Child's Name _____ Age: _____ Date of Birth _____

Mother's Name _____

Father's Name _____

Address _____

City/Town _____State_____Zip _____

Home Phone: _____ Mother's Work Phone: _____

E-mail: _____ Father's Work Phone: _____

Birth Weight _____ Birth Length _____

Current Weight _____ Current Length/Height _____

Type of Birth: ❑ Normal Vaginal ❑ Forceps ❑ Breech ❑ Cesarean ❑Induced Labor

❑Home❑Birthing Center❑ Hospital

APGAR Scores: _____ _____ Was there presence at birth of: ❑Jaundice (Yellow) ❑Cyanosis (Blue)

Congenital Anomalies/Defects: _____

Infant Feeding: ❑ Breast ❑ Bottle ❑ Formula

Hours of Sleep per Night: _____Quality of Sleep: ❑ Good ❑ Fair ❑ Poor

Date of Last Visit to MD: _____ Purpose: _____

Immunization History: _____

Purpose of This Appointment: _____

Has Your Child Been Treated on an Emergency Basis? ❑ Yes ❑ No If yes, describe:

_____

Authorization for Care of a Minor

I hereby authorize this clinic and its doctor(s) to administer care as they so deem necessary to my son/daughter/ward.

Parent/guardian signature: _____ Date: _____

I realize that I am responsible for all fees charged by this clinic and that I will pay for all services as they are performed. X-rays remain the property of this clinic.

Parent/guardian signature: _____ Date: _____

Pediatric Case History

Any problems getting pregnant? _____

Any problems during pregnancy?(e.g. immune deficiencies, chronic fatigue, gestational diabetes)

_____

Problems during labor/delivery?_____

Developmental History:*At what age did yourchild:*

Respond to sound	____mos	Crawl	____ mos	Stand	____ mos
Hold head up	____mos	Sit Alone	____ mos	Walk Alone	____ mos
Follow an object with his/her eyes	____ mos				

Childhood Diseases: ❑ Chickenpox ❑ Rubella❑Mumps❑Measles ❑ Whooping Cough

Other: _____

Has this child ever suffered from:

❑ Dizziness	❑ Diabetes	❑ Arthritis	❑ Neuritis	❑ Anemia
❑ Poor Appetite	❑ Bed Wetting	❑ Fainting	❑ Neck Problems	❑ Joint Problems
❑ Backaches	❑ Tuberculosis	❑ Headaches	❑ Digestive Disorders	❑ Asthma
❑ Hyperactivity	❑ Walking Problems	❑ Arm Problems	❑ Leg Problems	❑ Heart Trouble
	❑ Hypertension	❑ Sinus Trouble	❑ Broken Bones	❑ Orthopedic Problems
❑ Paralysis				
❑ Colds/Flu	❑ Chronic Earaches	❑ Allergies	❑ Sugar Concentration	❑ Constipation
	❑ Diarrhea	❑ Muscle Jerking	❑ Growing Pains	❑ Behavioral Problems
	❑ Ruptures/Hernias			
	❑ Rheumatic Fever	❑ Convulsions/Seizures		

Present History: _____

_____

Has your child had any injuries? (fractures, stitches, falls, sports-related, etc.) Please list dates, injury and treatment: _____

_____

Is your child on any medications? Please list, indicating dose/frequency: _____

_____

What sports does your child participate in?_____

_____

Are there concerns about your child's:

❑Balance	❑Behavior	❑Hyper/hypo sensitivity to touch
❑Hearing	❑Clumsiness	❑Smell
❑Vision	❑Ability to sit still	❑Speech

❑Difficulty in school (e.g. reading, hand writing, spelling, etc.)