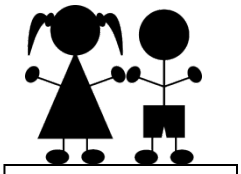

PEDIATRIC PATIENT INTRODUCTION FORM

Date:_____

Child's Name:_____ Age:____ Date of Birth:_____ Sex: M F

Street Address:_____ City, ST, Zip:_____

Parent's Name:_____

Phone:_____ Email:_____

Whom may we thank for referring you to our office? _____

Reason for coming to our office: _____

Name of Person Responsible for the Account:_____

Relationship to Patient:_____ Preferred Phone #:_____

Address (if different than above): _____

Insurance Company: _____ Name of Insured:_____

Relationship to Patient:_____ Date of Birth:_____

Present Health Challenge(s)

For what health challenge(s) is your child here for? When did it begin?

_____

Has your child seen other healthcare practitioners for this? What did they recommend?

_____

What was the outcome of prior treatment/recommendations?

_____

Is this dysfunction getting progressively worse? _____Yes _____No

Health History

__Anemia
__Arthritis
__ADHD
__Allergies
__Anxiety
__Arm/Elbow Pain
__Asthma
__Autism
__Backaches
__Behavioral Issues
__Bed Wetting
__Blood Disorders
__Broken Bones:_____
__Chest Pain
__Chronic Earaches
__Colic
__Concussions
__Constipation
__Convulsions
__Cough/Wheeze
__Diabetes
__Digestive Problems
__Dizziness
__Eczema
__Fainting
__Fever/Chills
__Frequent Colds
__Growing Pains
__Headaches
__Heart Condition
__Hernias
__Hyperactivity
__Hypertension
__Joint Pain
__Diarrhea
__Insomnia
__Itchy Eyes
__Knee/Foot Pain
__Leg/ Hip Pain
__Muscle Pain
__Neck Pain
__Nightmares
__Poor Appetite
__Poor Memory
__Rashes
__Reflux/Spitting Up
__Runny Nose
__Scoliosis
__Sinus Trouble
__Sprains/Strains
__Stomach Aches
__Unusual Moles
__Other:_____

Name of Pediatrician:_____ Date of Last Visit:_____

Current Medications & Vitamins:_____

Past Trauma (falls, sports injuries, accidents, etc)_____

Past Surgeries:_____

Prenatal History

Location of Birth: _____Home _____Birthing Center _____Hospital

Complications during pregnancy: Y – N List:_____

Medications during pregnancy/delivery:_____

Cigarette/Alcohol use during pregnancy: Y – N

Birth interventions: _____Forceps _____Vacuum _____Caesarian

Complications during delivery: Y – N List:_____

Birth weight _____ Birth Length _____

Feeding History

Breast Fed: Y – N How long?_____ Formula Fed: Y – N How long/Type?_____

Introduced to cereal at _____months. Solids at _____months. Cow's milk at _____months

Food/Juice allergies or intolerances Y – N List: _____

Developmental History

Sleep (hours per night) _____ Problems sleeping? _____

Medical/Vaccination History

Has your child ever had an adverse reaction to a prescription or over-the-counter medication?

Y – N

If yes, please explain: _____

Has your child been vaccinated? Y – N Adverse reactions to any vaccine? _____

Childhood Diseases

___Chicken Pox: Age____ * ___Mumps: Age____ * ___Rubella: Age_____

___Whooping Cough: Age____ * ___Measles: Age____ * ___Tuberculosis: Age____

___Meningitis: Age____ * ___Other: Age____

CONSENT FOR TREATMENT OF MINOR

I hereby certify that the information I have provided is correct and accurate to the best of my knowledge.

I, _____, as the parent/guardian of this child, _____, hereby grant permission for my child to receive examination and chiropractic treatment as deemed necessary.

_____ _____

Signature of Parent or Guardian Date