

Wilcox Family Chiropractic
Pediatric Patient Introduction (Ages Two Years +)

Childs Name: _____ Childs Date of Birth: _____
Age: ____ Sex: ____ Number of Siblings: ____ Referred By: _____
Mother's Name: _____ Father's Name: _____
Address: _____ City/Town: _____ State: ____ Zip: _____
Home Phone: _____ Mother's Cell Phone: _____ Father's Cell Phone: _____
Email Address: _____

How did you hear about us? _____
Pediatric/Family MD: _____
Date of Last Visit: _____ Purpose: _____
Immunization History: _____
Number of doses of antibiotics your child has taken: During the past six months ____ During his/her 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: _____

At what age, if ever, did this child suffer from the following childhood diseases?
Chicken Pox _____ 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 Disorders | <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/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"/> Allergies to _____ |
| <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"/> Broken Bones | <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: _____

Has this child ever sustained injuries in an auto accident? _____ If yes, please explain: _____

Present History: _____

Surgery: _____

Medications: _____

Accidents: _____

Family History: _____

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AUTHORIZATION FOR CARE OF MINOR

I hereby authorize this office and its doctor(s) to administer care as they deem necessary to my son/daughter/ward
(Upon approval of parent or guardian).

Signed: _____ Witnessed: _____ Date: _____

I realize that I am responsible for all fees charged by this office and I agree to pay for all services provided. X-Rays
remain the property of this office.

Signed: _____ Date: _____