Wilcox Family Chiropractic

Pediatric Patient Introduction

Childs Name: _____ Childs Date of Birth: _____

Age: ____ Sex: ____ Number of Siblings: ____ Referred By: _____

Birth Weight: _____ Birth Length: _____ Current Weight: _____ Current Length: _____

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? _____

Third Trimester Presentation: Vertex_____ Breech_____ Transverse_____ Face/Brow_____

Type of Birth: Normal Vaginal_____ Forceps_____ Cesarean_____ Suction Cap or Vacuum_____

Location: Home_____ Birthing Center_____ Hospital _____

Problems During Pregnancy: _____

Problems During Labor/Delivery: _____

Apgar Scores: ____ ____ Was there presence at birth of: Jaundice (Yellow)? _____ Cyanosis (Blue)? _____

Congenital Anomalies/Defects? _____ If Yes, Please Explain: _____

Infant Feeding: Breast _____ Bottle _____ If Bottle, Which formula? _____

Number of Hours Sleeping per Night? Quality of Sleep: Good _____ Fair _____ Poor_____

Obstetrician/Midwife: _____

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: _____

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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: _____

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PEDIATRIC CASE HISTORY

Delivery/Birth History: _____

_____

_____

_____

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?

Chicken Pox_____ Mumps_____ Measles_____ Rubella_____

Rubeola _____ Whooping Cough_____ Other _____

Has this child ever suffered from:

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

Has this child ever suffered the following spinal traumas?

□ Fall in baby walker	□ Fall from bed or couch	□ Fall off skateboard or skates
□ Fall from crib	□ Fall off swing	□ Fall off bicycle
□ Fall from highchair	□ Fall off slide	□ Fall down stairs
□ Fall from changing table	□ Fall off Monkey Bars	□ 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: _____