



Pediatric Confidential Patient Information

Name: _____ Date of Birth ____/____/____ Age ____ Sex: M F

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Emergency Contact Name _____ Emergency Contact Phone Number _____

Pediatrician: _____ Phone Number _____ May we contact them? Yes No

Primary health concern that brings you to a chiropractor? _____

When did this begin? _____

Are the current issues due to an injury? Yes No Date of injury ____/____/____

How did you hear about our office? _____

How would you like us to handle your problem? Resolve Existing Condition OR Overall wellness

Had past chiropractic care? Yes No When? _____

Please list all surgeries, falls, auto accidents and injuries (regardless how severe) with dates:

Medications:

Please list all prescription and over the counter medications

Name Purpose Dosage

Please list all known allergies _____

HEALTH CONCERNS – Please mark all that apply (past or present)

- | | | |
|---|---|--|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Chronic Colds/Cough | <input type="checkbox"/> Gas Pain/Bloating |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Colic/Excessive Crying | <input type="checkbox"/> Nausea/Vomiting |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Constipation | <input type="checkbox"/> Plagiocephaly |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Reflux/GERD |
| <input type="checkbox"/> Autism/Asperger's | <input type="checkbox"/> Depression | <input type="checkbox"/> Sensory Processing Disorder |
| <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Difficulty Sleeping | <input type="checkbox"/> Skin conditions/Eczema |
| <input type="checkbox"/> Bladder/Urination Issues | <input type="checkbox"/> Ear/Sinus Infections | <input type="checkbox"/> Speech Challenges |
| <input type="checkbox"/> Chronic Congestion | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Torticollis |

Other: _____

PREGNANCY HISTORY: (if yes to any of the following, please explain)

Fertility issues? _____

Any smoking or drinking? _____

Any exercising? _____

Notable physical or emotional stress? _____

Any illness while pregnant? _____

LABOR/DELIVERY HISTORY:

Delivery: Difficult Vaginal Scheduled C-Section Emergency C-Section Forceps
 Premature delivery Vacuum

How long were you in labor? _____

Complications: Breech Epidural Induced

Baby's height and weight at birth: _____

POSTNATAL HISTORY:

Breastfed? _____ If yes, how long? _____

Formula fed? _____ If yes, how long and what type? _____

At what age did you introduce: Solids? _____ Cow's milk? _____

Has your child received any antibiotics? _____

If so, what for and how many rounds? _____

Did/does your child frequently arch their back or bang their head? _____

If so, explain: _____

Is your child vaccinated? _____ If yes, any vaccine reactions? _____

REASON FOR CARE:

Biggest health concern: _____

When did it begin? _____

Is it getting better or worse? _____

What makes the problem better? _____

What makes the problem worse? _____

Worse during (circle): morning afternoon evening during sleep

What care have you received for this condition: _____

What is this affecting that is most important in your child's life? _____

What are your top 3 health goals for your child?

1) _____

2) _____

3) _____
