Pediatric Patient Introduction

Child's Name:_____ Mother's Name:_____

Last First Middle Init Last First Middle Init

Birth date:_____ Age:_____ Sex:_____ Father's Name:_____

Last First Middle Init

Address:_____ City:_____ Zip:_____

Mother's Phone:_____ Father's Phone:_____ Email Address:_____

Type of Birth: Normal Vaginal ____ Forceps ____ Breech ____ Cesarean ____

Hospital ____ Home ____ Birthing Center ____

Problems During Pregnancy:_____

Problems During Labor/Delivery:_____

Was there presence of: ____Jaundice (Yellow) ____Cyanosis (Blue)

Congenital Anomalies/Defects:_____

Current Weight: _____ Length: _____

Infant Feeding: Breast ____ Bottle ____ Formula ____

No. Hours Sleep Per Night:_____ Quality of Sleep: Good____ Fair ____ Poor ____

Date of Last Visit to MD:_____ Purpose:_____

Immunization History:_____

Purpose of this appointment: :_____

What other health care have you received for this/these problems: _____

_____

When did this begin?_____

Has your child ever been treated on an Emergency basis? (If yes, please describe):_____

_____

Who is responsible for this account?_____

I understand and agree that health and accident insurance are an arrangement between an insurance carrier and myself. Furthermore, I understand that DeHart Chiropractic Clinic will prepare any necessary reports and forms to assist me in making collection from the insurance carrier and that nay amount authorized go be paid directly this chiropractic office will be credited to my account on receipt. However, I clearly understand and agree that all the services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Signature:_____ Date:_____

(parent or guardian)

Pediatric Case History

Childhood Diseases: ____Chickenpox ____Rubella ____Rubeola

____Mumps ____Measels ____Whooping Cough

Surgery:_____

Medications:_____

Accidents:_____

Present History:_____

_____

_____

_____

Has this child ever suffered from:

- ☐ Dizziness
- ☐ Diabetes
- ☐ Neuritis
- ☐ Anemia
- ☐ Poor Appetite
- ☐ Bed Wetting
- ☐ Fainting
- ☐ Neck Problems
- ☐ Joint Problems
- ☐ Backaches
- ☐ Tuberculosis
- ☐ Headaches
- ☐ Digestive Probs
- ☐ Rheumatic Fever
- ☐ Hyperactivity
- ☐ Convulsions
- ☐ Walking Problems
- ☐ Arm Problems
- ☐ Heart Trouble
- ☐ Hypertension
- ☐ Asthma
- ☐ Sinus Trouble
- ☐ Orthopedic Probs
- ☐ Paralysis
- ☐ Broken Bones
- ☐ Leg Problems
- ☐ Chronic Earaches
- ☐ Colds/Flu
- ☐ Allergies
- ☐ Constipation
- ☐ Diarrhea
- ☐ Muscle Jerks
- ☐ Hernias
- ☐ Behavior Probs
- ☐ “Growing Pains”