Dr. Keisha Pitt
320 Prospect Place
Alpharetta, Georgia
30005

Pediatric History

Child's Name _____ Mother's Name _____
Last First MI Last First MI

Date of Birth____ ____ _____Age_____ SSN:_____ Father's Name _____
Last First MI

Sex _____ Birth Weight_____ Current Weight_____

Address_____ City _____ State _____ Zip_____

Home Phone _____ Work Phone _____ Cell Phone _____ email address_____

Type of Birth: Normal/vaginal_____ Forceps_____ Breech_____ Cesarean_____
Home_____ Hospital_____

Problems during pregnancy?_____

_____

Problems during labor/delivery?_____

_____

APGAR Scores: _____ _____ Present at Birth? Jaundice (yellow) _____ Cyanosis (blue) _____

Congenital Anomalies/Defects: _____

Infant Feeding: Breast_____ Bottle_____ Formula_____

Quality of Sleep: Good_____ Fair_____ Poor_____

Immunization History_____

Any childhood diseases? _____

Purpose of Last Visit to MD_____ Date_____

Purpose of This Appointment_____

_____

Development History: At what age did the child....?

Smile_____ Stand_____ Walk alone_____ Crawl_____ Hold objects with hands_____
Hold head up_____ Sit alone_____ Talk_____ Follow object with his/her eyes_____

Has this child ever suffered from: (Circle all that apply)

Dizziness	Backaches	Blood disorders	Stomachaches
Diabetes	Headaches	Heart trouble	Chronic Earaches
Anemia	Digestive disorders	Asthma	Colds/Flu
Poor appetite	Rheumatic fever	Sinus trouble	Allergies
Bed wetting	Hyperactivity	Diabetes/Hypoglycemia	Constipation
Fainting	Seizures	Paralysis	Diarrhea
Neck problems	Walking problems	Broken bones	Other:_____
Joint problems	Arm problems	Leg problems	_____
Behavioral problems	Ruptures/Hernias	'Growing pains'	_____

Surgery_____

Medications_____

Accidents_____

Family History_____

_____

Has Your Child Ever Been Treated on Emergency Basis? _____

If so, why?_____

Do you have any type of health insurance? _____ Company: _____ ID Number:_____

Please give us your insurance card so we may photocopy it.

Consent To Treat Minor

I hereby authorize _____ and whomever he may designate as his assistants to administer treatment, as he so deems necessary to my child, _____.

Dated _____day of _____ 20____

Signed_____

I agree to assume responsibility for any charges created by chiropractic care. I also give consent for my child to be examined and/or treated by Dr. Pitt and her staff.

Parent signature _____ Date _____