Pediatric Patient History Form

Welcome to Journey Family Chiropractic!

Child's Name_______________________________________ Parent's Name_________________________________

Last First MI Last First MI

Date of Birth______________________ Age_____________ Parent's Name____

Last First MI

Address______________________________ _________________________ City______________________ State____________ Zip_____________

Home Phone____________________ Cell Number _________________________ Cell Provider ___________ Work Phone_______________

SSN_____________________ Gender: M F Non-specified Birth Weight _______________________Current Weight _______________

Email______________________________@_______________ Who referred you to our office?_____________________________

Type of Birth: Normal/Vaginal______ Forceps_______ Breech_______

Home______ Hospital______ Cesarean_______

Problem during pregnancy? ____

____

Problem with labor/delivery?

____

____ Cyanosis (blue)_________

APGAR Scores:__________________ ____________________ Present at Birth? Jaundice (yellow) ___________

Congenital Anomalies/Defects: ____ _________

Infant Feeding: Breast___________ Bottle___________ Formula___________

Quality of Sleep: Good____________ Fair_____________ Poor_____________

Immunization History____

Any childhood diseases?____ Date_______________

Purpose of Last Visit to MD____

Purpose of This Appointment____

____

Development History: At what age did the child…?

Smile: Stand: Walk alone: Crawl: Hold object 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	Behavioral problems	Arm problems	"Growing pains"
Diabetes	Backaches	Ruptures/hernias	Stomachaches
Anemia	Headaches	Blood disorders	Chronic earaches
Poor appetite	Digestive disorders	Heart troubles	Cold/Flu
Bed wetting	Rheumatic fever	Diabetes/hypoglycemia	Allergies
Fainting	Hyperactivity	Paralysis	Constipation
Neck problems	Seizures	Broken bones	Diarrhea
Joint problems	Walking problems	Leg problems	Asthma

*Any other:____

Surgery____ ______________

Medications____ ______________

Accidents____

Family History____

Has your child ever been treated on emergency basis: Y or N If so, why? ____

Do you have any type of health insurance? Y or N if so, Company ___________________________ ID #______________________

Please provide us with your insurance card so we may photocopy it for our files and verify benefits for you for review at your next visit

Consent to Treat Minor

I hereby authorize___________________________ and whomever she may designate as her assistants to administer treatment, as she deems necessary to my child________________________________.

Dated__________________ day of______________________20_________.

Signed____.

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

Parental Signature____ Date__________________________________