Ethnicity: Hispanic or Latino/ Other **Preferred Language**: ______________________

Race: Asian/ African Am. / Am. Indian or Alaskan Native/
Other/ Native Hawaii or Pacific Island/ White

Name of Pediatrician: ____________________ Date of Last Visit: ____________________
Current Medications & Vitamins: ____
Past Trauma (falls, sports injuries, accidents, etc.) ____
Past Surgeries: ____

Prenatal History
Location of Birth: ___ Home ___Birthing Center ___Hospital
Complications during pregnancy: Y-N List:
____
Medications during pregnancy/delivery: ____
Cigarette/ Alcohol use during pregnancy: Y-N
Birth intervention: ___ Forceps ___ Vacuum ___Caesarian
Complications during delivery: Y-N List:
____
Birth Weight________________ Birth Length________________

Feeding History
Breast Fed: Y-N How long? ___________ Formula Fed: Y-N How long? ___________ Type:
____
Introduced to cereal at ____ months. Solids at ____ months. Cow's milk at ____months
Food/juice allergies or intolerances Y-N List: ______________________________

Developmental History
Sleep (Hrs per night) _________ Problems sleeping ______________________
Medical/Vaccination History

Has your child ever had an adverse reaction to a prescription or over-the-counter medication? Y-N
If yes, please
Explain:
____
Has your child been vaccinated? Y-N Adverse reactions to any
Vaccine? ______________________________

Childhood Disease
___Chicken Pox: Age ____* ___ Mumps: Age ____* ___Rubella: Age ____* ___ Whooping cough: Age ____
___ Measles: Age ____* ___Meningitis: Age ____* ___ Tuberculosis: Age ____* ___ Other: Age ____

Consent For Treatment of Minor

I hereby certify the information I have provided is correct and accurate, to the best of my knowledge.
I, ________________________, as the parent/guardian of this child, ____________________, hereby grant permission for my child to receive examination and chiropractic treatment as deemed necessary.

______________________________ ______________
Signature of Parent or Guardian Date

PEDIATRIC PATIENT INTRODUCTION CARD

Date: ___________

Child's Name: ______________________ Age: _________ Date of Birth: _________________ Sex: M F
Street Address: ____ City, ST, Zip: _____________________
Parent's Names: ___________________________________
Phone: _______________________________________ Email: ______________________________________
Whom may we think for referring you to our office? ____
Name of Person Responsible for the Account: ____
Relationship to Patient: ____________________________ Preferred Phone #: ___________________
Address (if different than above): ____
Insurance Company: ___________________________ Name of Insured: ____________________________
Relationship to Patient: ________________________ Date of Birth: ______________________________

Present Health Challenge(s)

For what health challenge(s) is your child here for? When did it begin?

____

Has your child seen other health care practitioners for this? What did they recommend?

____

What was the outcome of prior treatment/recommendations?

____

Is this dysfunction getting progressively worse? _______Yes ________No

Health History

Symptoms: Please check any current or past problems your child has on the list below:

__Anemia
__Arthritis
__ADHD
__Allergies
__Anxiety
__Arm/Elbow Pain
__Asthma
__Autism
__Backaches
__Behavioral Issues
__Bed wetting
__Blood disorders
__Broken bones: ______________
__Chest Pain
__Chronic Earaches
__Colic
__Concussions
__Constipation
__Convulsions
__Cough/Wheeze
__Diabetes
__Diarrhea
__Digestive Problems
__Dizziness
__Eczema
__Fainting
__Fever/Chills
__Frequent Colds
__Growing Pains
__Headaches
__Heart Condition
__Hernias
__Hyperactivity
__Hypertension
__Joint Pain
__Insomnia
__Itchy Eyes
__Knee/Foot Pain
__Leg/Hip Pain
__Muscle Pain
__Neck Pain
__Nightmares
__Poor Appetite
__Poor Memory
__Rashes
__Reflux/Spitting up
__Runny nose
__Scoliosis
__Sinus Trouble
__Sprains/Strains
__Stomach Aches
__Unusual Moles
__Other ____________