



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 thank for referring you to our office? _____

Reason for coming 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:

- | | | |
|--|---|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Constipation | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Itchy Eyes |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Cough/Wheeze | <input type="checkbox"/> Knee/Foot Pain |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Leg/Hip Pain |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Muscle Pain |
| <input type="checkbox"/> Arm/Elbow Pain | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Neck Pain |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Nightmares |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Eczema | <input type="checkbox"/> Poor Appetite |
| <input type="checkbox"/> Backaches | <input type="checkbox"/> Fainting | <input type="checkbox"/> Poor Memory |
| <input type="checkbox"/> Behavioral Issues | <input type="checkbox"/> Fever/Chills | <input type="checkbox"/> Rashes |
| <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Reflux/Spitting up |
| <input type="checkbox"/> Blood disorders | <input type="checkbox"/> Growing pains | <input type="checkbox"/> Runny Nose |
| <input type="checkbox"/> Broken bones: _____ | <input type="checkbox"/> Headaches | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Chronic Earaches | <input type="checkbox"/> Hernias | <input type="checkbox"/> Sprains/Strains |
| <input type="checkbox"/> Colic | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Stomach Aches |
| <input type="checkbox"/> Concussions | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Unusual Moles |
| | <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Other _____ |

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 Diseases

___ 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 that 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