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Pediatric Patient Introduction

Child's Name:_____ Chart Number:_____

Address:_____

City/Town:_____ State:_____ Zip:_____

Birthdate:_____ Age:_____ Referred to Office by:_____

Home Phone: (___) _____-_____

Parent's Name:_____ Work Phone: (_____) _____-_____

Parent's Name:_____ Work Phone: (_____) _____-_____

Reason for today's visit: WELLNESS EXAM or describe the complaint, when was its onset?

_____

_____

_____

Duration:_____ Frequency:_____

What makes it worse?_____

What makes it better?_____

How does your child communicate the problem? _____

_____

Who is your pediatrician? _____

Has your child been seen for this complaint? _____

Has your child had any x-rays taken for this or other conditions? ( ) Yes ( ) No

When? _____

Facility? _____

Of what? _____

Has your child undergone any surgery? _____

_____

Has the child ever received chiropractic care? ( ) No ( ) Yes

Chiropractor's name _____

Treatment_____

Clinical Health History

Pregnancy History

a) Number of pregnancies: 1 2 3 4 5 6 7 8 9 10 ____
b) Number of miscarriages: ( ) None ( ) Yes [how many? _____]
c) Number of stillbirths: ( ) None ( ) Yes [how many? _____]
d) Was this pregnancy an in vitro fertilization? ( ) No ( ) Yes
e) Was this pregnancy artificial insemination? ( ) No ( ) Yes

Antenatal

a) Did mother receive chiropractic care during pregnancy? ( ) Yes ( ) No
b) Did mother receive prenatal care? ( ) Yes ( ) No In which month? _____
c) Did mother go to prenatal classes for this pregnancy? ( ) Yes ( ) No
d) Duration of pregnancy: (months) 6 7 8 9 10 _____weeks
e) Mother's health: ( ) Healthy ( ) Minor Illness _____

( ) Serious Illness _____

Was the mother exposed to any of the following:

( ) X-rays ( ) smoke _____packs/day ( ) Alcohol

( ) Caffeine ( ) Medication _____ by:_____

( ) Ultrasound: Trimester _____ Number of times _____

Reason: _____

( ) Amniocentesis: Trimester _____ Number of times _____

Reason: _____

( ) Chronic Villi sampling: Trimester _____ Number of times _____

Reason: _____

( ) Prenatal vitamins w/ iron _____

f) Mother's nutritional status: ( ) Good ( ) Poor ( ) Vegetarian
( ) Meat Eater ( ) Junk food eater

g) Mother's attitude: ( ) Planned ( ) Unplanned
( ) Very Emotional _____

Natal

a) Labor: number of hours _____ ( ) Difficult ( ) Uncomplicated

Was labor induced? ( ) Yes ( ) No

b) Delivery: ( ) Vaginal ( ) C-Section ( ) Forceps
( ) Complicated ( ) Vacuum ( ) Anesthesia

Drug _____

Emotional state of mother? _____

c) Place of birth: ( ) Hospital ( ) Home ( ) Birthing Center
( ) Other _____

d) Present at birth: ( ) Physician ( ) Nurse Midwife ( ) Lay Midwife ( ) Other
Name _____

e) Birth weight: _____lbs. _____ ozs. Length: _____inches

f) Condition of child after birth: ( ) good ( ) fair ( ) poor
APGAR Scores: 1 minute_____ 5 minutes_____

g) Congenital anomalies/defects _____
_____

Neonatal

( ) Fever ( ) Convulsions ( ) Cyanosis (blue) ( ) Jaundice (yellow)

( ) Infections ( ) Rash ( ) Breath Problems ( ) Sucking difficulty

( ) Club Feet ( ) Anomalies _____

Infancy

a) Nutrition: ( ) Breast Fed [How long? _____]
( ) Bottle Formula _____
( ) Allergies to formula _____

b) Digestion ( ) Colic ( ) Projectile Vomiting ( ) Excess Crying
_____

c) Introduction to solid foods: _____

Allergies: _____

Favorites: _____

REVIEW OF SYSTEMS – Current major Problems (past three months)

1) Special Senses: ( ) No problems ( ) Smell ( ) Sight ( ) Hearing
( ) Speech ( ) Touch _____

2) Dentition: ( ) No problems ( ) Cavities _____ ( ) Discolored Teeth

( ) Braces _____

( ) Special Dental Care _____

3) Cardiovascular: ( ) No problem ( ) Dyspnea ( ) Cyanosis (blue)

( ) Edema ( ) Precordial pain ( ) Syncope ( ) Murmur _____

4) Respiratory: ( ) No problem ( ) Cough ( ) Congestion
( ) URI's ( ) Ear infections ( ) Allergies _____
( ) Tubes in the ears _____

5) Genitourinary: ( ) No problem ( ) Enuresis ( ) Diuresis ( ) Yeast
_____

6) Nervous System: ( ) No problem ( ) Convulsion ( ) Nervous
( ) Stare ( ) Seizures ( ) Restless ( ) Very Sound
( ) Sleepwalks ( ) Nightmares ( ) Gets up often
hrs. sleep/night _____

7) Musculoskeletal: ( ) No problem ( ) Muscle Weakness ( ) Paresis
( ) Paralysis ( ) Spastic ( ) Palsy _____ ( ) Hypotonia _____
( ) Growth Spurts _____ ( ) Joint pain _____
( ) Spinal curves _____

8) Gastrointestinal: ( ) Constipation ( ) Diarrhea ( ) Irritable ( ) Ulcer
( ) Bowel Syndrome ( ) Reflux ( ) Intusseseption
times move bowels each day _____ ( ) small ( ) large
( ) hard ( ) soft ( ) dark ( ) light ( ) floats in toilet

Appetite: ( ) Excellent ( ) Good ( ) Fair ( ) Poor _____

Attitude towards food: _____

Supplements: _____

A) Growth and Development: Current Height: _____ Current Weight:_____
Developmental Milestones: ( ) Respond to sound at _____ mos.
( ) Follow object w/ eyes at ____ mos. ( ) Head control at _____ mos.
( ) Sit at ____ mos. ( ) Crawl on own at ____ mos.
( ) Walk at ____ mos. ( ) Abnormal crawl _____

Sleep Patterns: At what age did the child begin to sleep through the night _____

( ) sound ( ) restless ( ) nightmares ( ) talks ( ) walks

Toilet trained: ( ) Yes _____ years old ( ) No [difficult_____]

B) Habits: ( ) Nail biting ( ) Rocking ( ) Tantrums ( ) Thumb sucking
( ) Head Banging ( ) Masturbation ( ) Pica

C) Sexual Development ( ) Secondary sex characteristics/ year of appearance ___
( ) Menarche/ year of appearance _____
( ) Attitude _____

D) Discipline: ( ) WNL ( ) Tantrums ( ) Aggressive ( ) Violent
( ) Withdrawn ( ) Destructive _____

E) School Adjustment: _____

( ) Separation Anxiety ( ) Independent ( ) Shyness ( ) Friendly

( ) Hobbies _____ ( ) Sports _____

F) Eating Habits: # of meals a day _____

( ) Picky ( ) Constantly ( ) Junk ( ) NutraSweet

( ) Sweet ( ) Salty

Picky about certain textures _____

Favorites: _____

_____

Family Health History

Birth order of child _____

Family status at child's birth _____

Current status _____

Do all family members reside at same address _____

1) Natural mother's health Age _____

( ) Good ( ) Under Doctor's care ( ) Surgeries _____

( ) Chronic Illness ( ) Mental Health Care ( ) Emotional Instability

_____

2) Natural Father's health Age _____

( ) Good ( ) Under Doctor's care ( ) Surgeries _____

( ) Chronic Illness ( ) Mental Health Care ( ) Emotional Instability

_____

3) Siblings Health:

Name Age Health

a) _____

b) _____

c) _____

d) _____

e) _____

Family History (P) = Paternal (M) = Maternal (P/M) = Both sides

( ) Allergies ( ) Blood Dyscrasias ( ) Cancer ( ) Congenital Anomalies

( ) Epilepsy ( ) Tuberculosis ( ) Heart Disease ( ) Mental Illness

( ) Hypertension ( ) Kidney Disease ( ) Autism ( ) Hyperactivity

( ) Liver Disease ( ) Ulcer ( ) Chronic Colds ( ) Behavior Disorders

( ) Asthma ( ) Chronic Flu ( ) Colic ( ) Learning Disorders

( ) Enuresis ( ) Cerebral Palsy ( ) Strokes ( ) Chronic Otitis Media

( ) Hernia ( ) Leukemia ( ) Arthritis ( ) Difficulty Breastfeeding

( ) Nervous Disorder ( ) Other _____

I will be paying for my bill today with: ( ) cash ( ) insurance

Insurance company: _____

Insured's Name: _____

Membership/ Insured's ID#: _____ Group #: _____

Insured's Relationship to Patient: _____

Insured's Address: _____

Insured's Date of Birth: ____/_____/_____ Insured's Social Security #: _____

I realize that I am responsible for all fees charged by this clinic and that I will pay for all services as they are performed.

Date: _____ Signature: _____