PEDIATRIC INFORMATION FORM (BIRTH - 12 YEARS)

Patient Information

Name: _____ Date: _____

Date of birth: _____ Age: _____ Sex: ☐ Male ☐ Female

Parent/Guardian's name(s): _____

Street address: _____

City: _____ State: _____ Zip code: _____

Email address: _____

Home phone: _____ Cell phone: _____

Insurance Provider/ID#:

_____

Whom may we thank for referring you?

_____

Prenatal History

Any complications during pregnancy:

_____

Any alcohol? Yes/No Any tobacco? Yes/No Any vaccines/medication? Yes/No

Reason for vaccines/medication:

_____

Illness/infections during pregnancy:

_____

Ultrasounds or other testing:

_____

What things were done to stay healthy during pregnancy?

_____

Birth History

Place of birth: ☐ Home ☐ Birthing Center ☐ Hospital

Provider: ☐ Midwife ☐ OB-Gyn ☐ Other

Type of birth: ☐ Vaginal ☐ Cesarean

Were pain medications used? Yes/No Pitocin used? Yes/No

Was labor induced? Yes/No If yes, why? _ Birth trauma? ☐ Doctor assisted ☐

Twisting/Pulling ☐ Vacuum Extraction ☐ Forceps APGAR score if known: _____

Did your child have a misshaped skull/head? Yes/No

Did you breast-feed your child? Yes/No How long? _____

Any food allergies: _____

Has your child been vaccinated? Yes/No

Reason: ☐ Informed decision ☐ Recommended ☐ Didn't know I had a choice

Did your child have any negative reaction to the vaccines? Yes/No

If yes, were they reported? Yes/No

Has your child ever had any surgeries? Yes/No

If yes, elaborate:

Has your child been on antibiotics? Yes/No
If yes, how often and what purpose?

Is your child currently taking any medication? Yes/No
If yes, how often and what purpose?

Is your child currently taking any vitamins? Yes/No

Baby/Toddler (0-4)

Have any of the following occurred?

Jaundice	Colic	Reflux
Anemia	Frequent diarrhea	Fall from a changing table
Cyanosis	Constipation Sleeping	Fall out of crib
Seizures	problems Frequent	Fall off playground
Infections	fevers Frequent crying	Tumble down stairs
Tonsillitis	spells Repeated colds	Play in a Johnny Jumper
Frequent ear infections		Car accident

Other_____

Child (4 - 12)

Have any of the following occurred?

Fall from a tree	Stomach pains	Bed-wetting
Fall off a bicycle	Hyperactivity/Autism	Asthma
Fall on playground	Leg/Knee pains	Allergies
Sports accident	Scoliosis	Growing Pains
Car accident	Learning difficulties	Headaches/Migraines

Other _____

Which of the above bothers your child the most?

When did it begin? _____ Is it getting worse? Yes/No
Does it affect activity? ☐ Not at all ☐ Somewhat ☐ Always
Does your child participate in any athletic extra curricular activities? Yes/No
If yes, which ones?_____
Rate your child's diet: ☐ Well-balanced ☐ Average ☐ High sugar/processed foods
Does your child consume artificial sweeteners? Yes/No
Number of hours your child sleeps? _____hours/day
Sleep quality? ☐ Good ☐ Fair ☐ Poor
Is there anything else the Doctor should know?

Authorization to treat a Minor

I, _____ the undersigning parent/guardian having legal custody/guardianship of _____, a minor, do herby authorize, request, and direct the staff and doctors of Peak Chiropractic to perform in judgment any examination and chiropractic diagnosis or treatment which is deemed necessary.

Patient's name: _____
Parent/Guardian's signature: _____ Date: _____