



# 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