

### PEDIATRIC PATIENT INTRODUCTION CARD

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 you 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 Condidtion	<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:  No  Yes, List: \_\_\_\_\_

Medications during pregnancy/delivery: \_\_\_\_\_

Cigarette/Alcohol use during pregnancy:  No  Yes

Birth intervention: \_\_\_Forceps \_\_\_Vacuum \_\_\_Caesarian

Complications during delivery:  No  Yes, List: \_\_\_\_\_

Birth weight: \_\_\_\_\_ Birth length: \_\_\_\_\_

### FEEDING HISTORY

Breast Fed:  No  Yes, How long? \_\_\_\_\_

Formula Fed:  No  Yes, How long? \_\_\_\_\_ Type: \_\_\_\_\_

Introduced to cereal at \_\_\_\_\_ months. Solids at \_\_\_\_\_ months. Cow's milk at \_\_\_\_\_ months.

Food / juice allergies or intolerances:  No  Yes, List: \_\_\_\_\_

### DEVELOPMENTAL HISTORY

Sleep (hours per night) \_\_\_\_\_ Problems sleeping \_\_\_\_\_

### MEDICAL / VACCINATION HISTORY

Has your child ever had an adverse reaction to a prescription or over-the-counter medication?  No  Yes

If yes, please explain: \_\_\_\_\_

Has your child been vaccinated?  No  Yes, 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