



# Pediatric Application

(birth to 12 years old)

Today's Date: \_\_\_/\_\_\_/\_\_\_

Child's Full Name: \_\_\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_

Parent's/Guardian's Names: \_\_\_\_\_

Relation To Child: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: (Home) \_\_\_\_\_ (Cell) \_\_\_\_\_ Email: \_\_\_\_\_

Has your child ever been checked by a Doctor of Chiropractic?  Yes  No

If yes, who? \_\_\_\_\_ Were X-Rays taken?  Yes  No

## Prenatal History

- Is your child adopted?  Yes  No
- Did you take any medications?  Yes  No
- Did you have any complications and when?  Yes  No, Explain: \_\_\_\_\_
- Did you have an ultrasound during this pregnancy?  Yes  No, How often? \_\_\_\_\_
- Did you consume alcohol?  Yes  No
- Did you smoke?  Yes  No

## Birth History

- Birthing place:  Home  Birthing Center  Hospital
- Provider:  Midwife  OB-Gyn  Other: \_\_\_\_\_
- What position did you deliver in:  Squatting  On Back  
Other: \_\_\_\_\_
- Birth Trauma:  Doctor Assisted  Twisting and/or pulling  Vacuum Extraction  Forceps
- Newborn trauma (medical procedures and tests): \_\_\_\_\_
- APGAR score: At birth \_\_\_/10 ; at 5-minutes: \_\_\_/10 ;  Unsure
- Did your child have a misshaped skull/ head?  Yes  No
- Purple markings on their face/ head?  Yes  No
- Type of birth:  Vaginal  C-Section
- Was your labor induced?  Yes  No
- Any medications used?  Yes  No  
Type: \_\_\_\_\_
- Do you/did you breastfeed your child?  Yes  No, If yes, for how long? \_\_\_\_\_
- Does your child prefer one breast/side over the other?  Yes  No, If yes,  Right or  Left
- Does your child have any food or other allergies? List: \_\_\_\_\_
- Has your child been immunized according to the recommended schedule?  Yes  No
- Reason for vaccination:  Informed decision  Didn't know I had a choice  Recommended
- Did your child have any negative reactions to vaccinations?  Yes  No, Were they reported?  Yes  No
- Has your child ever had any surgeries?  Yes  No, Please explain: \_\_\_\_\_
- Have they ever been on antibiotics?  Yes  No, How many rounds? \_\_\_ Reasons: \_\_\_\_\_
- Is your child currently taking any meds?  Yes  No Type: \_\_\_\_\_
- Number of rounds of *other* prescription medications your child has taken: \_\_\_ Reason: \_\_\_\_\_
- Is your child currently taking any vitamins?  Yes  No Type: \_\_\_\_\_

## Baby/Toddler (0-4): Have/Did any of the following occur?

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Fall from a changing table  | <input type="checkbox"/> Tonsillitis       | <input type="checkbox"/> Frequent ear infections | <input type="checkbox"/> Reaction to Vaccines |
| <input type="checkbox"/> Repeated infections/colds   | <input type="checkbox"/> Constipation      | <input type="checkbox"/> Frequent fevers         | <input type="checkbox"/> Fall down stairs     |
| <input type="checkbox"/> Fall off of playground unit | <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Involvement in MVA      | <input type="checkbox"/> Colic                |
| <input type="checkbox"/> Play in a Johnny jumper     | <input type="checkbox"/> Fall out of crib  | <input type="checkbox"/> Inadequate weight gain  | <input type="checkbox"/> Frequent diarrhea    |
| <input type="checkbox"/> Other: _____                | Explain: _____                             |  |   |

## Child (5-12): Have/Did any of the following occur?

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Fall from a tree            | <input type="checkbox"/> Car Accident    | <input type="checkbox"/> Allergies / Asthma    | <input type="checkbox"/> Leg/Knee pain |
| <input type="checkbox"/> Fall off a bicycle          | <input type="checkbox"/> Sports Accident | <input type="checkbox"/> Hyperactivity/Autism  | <input type="checkbox"/> Bed Wetting   |
| <input type="checkbox"/> Fall off of playground unit | <input type="checkbox"/> Scoliosis       | <input type="checkbox"/> Learning difficulties | <input type="checkbox"/> Stomach pains |
| <input type="checkbox"/> Other: _____                | Explain: _____                           |  |  |

- Which of the above bothers your child the most? \_\_\_\_\_ Is it getting worse?  Yes  No
- When did it begin? \_\_\_\_\_ How often does the pain/issue occur?  Constant  Intermittent  Cyclic
- How much does the complaint affect daily activities/routines?  None  Somewhat  Frequent  Always

Please check any sports that your child plays:

- |                                     |                                     |                                     |                                    |  |
|-------------------------------------|-------------------------------------|-------------------------------------|------------------------------------|--|
| <input type="checkbox"/> Soccer     | <input type="checkbox"/> Football   | <input type="checkbox"/> Gymnastics | <input type="checkbox"/> Karate    | <input type="checkbox"/> Hockey            |
| <input type="checkbox"/> Lacrosse   | <input type="checkbox"/> Basketball | <input type="checkbox"/> Dance      | <input type="checkbox"/> Wrestling | <input type="checkbox"/> Baseball/Softball |
| <input type="checkbox"/> Volleyball | <input type="checkbox"/> Swimming   | <input type="checkbox"/> Tennis     | <input type="checkbox"/> Rugby     | <input type="checkbox"/> Other: _____      |

- How would you rate your child's diet?  Well balanced  Average  High amounts of sugar and processed food
- Does your child consume: Artificial sweeteners?  Yes  No or Fluoridated water?  Yes  No
- Number of hours your child sleeps? \_\_\_\_/day(nap) and \_\_\_\_/night

Is there anything else we should know about your child? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Authorization to Treat a Minor

I, \_\_\_\_\_, am the undersigning parent/person having legal custody/guardianship whomever s/he may designate as assistant to perform in judgment any examination and chiropractic diagnosis or treatment, which is deemed necessary.

Any specific written authorization you provide may be revoked at any time by writing to us as the address provided at the end of this notice.

Name of Patient: (please print) \_\_\_\_\_ Date of birth \_\_\_\_\_

Name of Parent/Guardian: (please print) \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_ Today's Date \_\_\_\_\_

## Insurance Information

Insurer's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Relation To Child: \_\_\_\_\_

Insurance Card (to be photocopied below):