

PEDIATRIC PATIENT INFORMATION

CASE NUMBER: _____

CHILD'S NAME: _____ MOTHER'S NAME _____
LAST FIRST MIDDLE

FATHER'S NAME _____
ADDRESS _____ CITY/TOWN: _____ STATE: _____ ZIP _____

HOME PHONE: _____

MOTHER'S WORK PHONE: _____ FATHER'S WORK PHONE: _____

BIRTH DATE: ____ / ____ / ____ AGE: ____ BIRTH WEIGHT: ____ CURRENT WEIGHT: ____

SEX: ____ NO. OF SIBLINGS: ____ BIRTH LENGTH: ____ CURRENT LENGTH: ____

TYPE OF BIRTH: NORMAL VAGINAL ____ FORCEPS ____ BREECH ____ CESAREAN ____

HOME: _____ BIRTHING CENTER: _____ HOSPITAL: _____

PROBLEMS DURING PREGNANCY: _____

PROBLEMS DURING LABOR/DELIVERY: _____

APGAR SCORES: _____ AT BIRTH: _____ JAUNDICE (YELLOW)
_____ CYANOSIS (BLUE)

CONGENITAL ANOMALIES/DEFECTS: _____

INFANT FEEDING: BREAST ____ BOTTLE ____ FORMULA ____
AT WHAT AGE DID THEY STOP? _____

NO. OF HOURS SLEEP AT NIGHT: ____ QUALITY OF SLEEP: GOOD ____ FAIR: ____ POOR: ____

OBSTETRICIAN/MIDWIFE: _____
NAME LOCATION

PEDIATRICIAN/FAMILY MD: _____
NAME LOCATION

DATE OF LAST VISIT TO MD: _____ PURPOSE: _____

IMMUNIZATION HISTORY: _____

PURPOSE OF THIS APPOINTMENT: _____

Has your child ever had chiropractic care? _____ Chiropractor's Name _____
Last date of visit _____

Insurance Information: _____
COMPANY POLICY#