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#