Pediatric Patient Introduction (3-7 yrs)

THE SOURCE CHIROPRACTIC

Date:_____

Child's Name:_____

Parent Name:_____ Parent Name:_____
First Last First Last

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Parent Work Phone:_____
Birth Date:_____/_____/_____ Age: _____ Sex: Male/Female Number of Siblings:_____
Current Weight:_____ Current Height:_____

Pregnancy & Fertility History:

Any fertility issues?	Yes	No	If yes, please explain: _____
Did mother smoke?	Yes	No	If yes, how many per week? _____
Did mother drink?	Yes	No	If yes, how many per week? _____
Did mother exercise?	Yes	No	If yes, please explain: _____
Was mother ill?	Yes	No	If yes, please explain: _____
Any ultrasounds?	Yes	No	If yes, please explain: _____

Please explain any notable episodes of mental or physical stress during your pregnancy:

_____

_____

_____

Please explain any other concerns or notable remarks about your child's conception or pregnancy:

_____

_____

_____

Labor & Delivery History

Child's birth was: Vaginal Birth Scheduled C-section Emergency C-section

At how many week's was your child born? _____

Child's birth was: At home At a birthing center At a hospital Other:

Obstetrician/Midwife's Name: _____

Please circle any applicable interventions or complications:
Breech Induction Pain meds Epidural Episiotomy Vacuum extraction Forceps
Medical Induction Other

Please describe any other concerns or notable remarks about your child's labor and/or delivery.

_____

_____

_____

Growth & Development History:

Was your child breastfed? Yes No If yes, how long? _____
Difficulty with breastfeeding or single side dominance? Yes No

Did/does your child frequently arch their neck/back, feel stiff, or bang their head? Yes No
If yes, please explain: _____

Does your Child seem to be developing typically for their age? Yes No
If no, has your child been evaluated or received services? _____

Were any developmental milestones delayed? Yes No
If yes, which ones? _____
_____

Please list any food intolerance or allergies, and when they began: _____
_____
_____

Please list your child's hospitalization and surgical history, including the year: _____
_____
_____

Please list any major injuries, accidents, falls and/or fractures your child has sustained in his/her lifetime, including the year: _____
_____
_____

Have you chosen to vaccinate your child? No Yes, on an alternate schedule Yes, on schedule
If yes, please list any vaccination reactions: _____
_____

Has your child received any antibiotics? Yes No
If yes, how many times and list reason:_____
_____

Night terrors or difficulty sleeping? Yes No
If yes, please explain: _____
_____

Behavioral, social or emotional issues? Yes No
If yes, please explain: _____
_____

How many hours per day does your child typically spend watching a TV, computer, tablet or phone?
_____
_____

How would you describe your child's diet?

Mostly whole, organic foods Pretty average High amount of processed foods

Health Concerns:

Please list any health concerns below:

_____

_____

_____

When did the condition first begin? _____

How did the problem start? Suddenly Gradually Post-Injury

Has your child ever received care for this condition before? Yes No

If yes, please explain: _____

Is this condition: Getting worse Improving Intermittent Constant Unsure

What makes the problem better? _____

What makes the problem worse?_____

Health Goals:

What are your top three health goals for your child?

1. _____
2. _____
3. _____

CIRCLE ANY AND ALL OF THESE PROBLEMS WHICH HAVE HAPPENED

DIZZINESS/ VERTIGO	ASTHMA	KIDNEY PROBLEMS	CHRONIC FATIGUE
HEADACHES/MIGRAINES	TROUBLE EATING	BLADDER PROBLEMS	RASHES
ANTIBIOTICS	ALLERGIES	BED WETTING	TROUBLE SLEEPING
EAR INFECTIONS	ARM NUMBNESS	SCIATICA	ADD / ADHD
GRATING OF NECK	ARM PAIN	LEG NUMBNESS	GERD
DIFFICULT BREAST FEEDING	NIGHT TERRORS	FEET NUMBNESS	ANXIETY
NECK PAIN/ STIFFNESS	SHOULDER PAIN	LOW BACK PAIN	NERVOUSNESS
TORTICOLLIS	HEART DISORDERS	HIP PAIN	EPILEPSY
COLIC	MID BACK PAIN	LEG PAINS	AUTISM SPECTRUM DISORDER
CHRONIC SINUS	STOMACH DISORDERS	KNEE PAIN	VACCINE REACTION
THROAT ISSUES	NAUSEA	LIVER DISEASE	OTHER _____
SENSORY PROCESSING ISSUES	REFLUX	BOWEL PROBLEMS TONGUE/LIP TIE	_____

Authorization for Care of Minor

I hereby authorize The Source Chiropractic and doctor(s) to administer care, as they so deem necessary to my son/daughter/ward (upon approval of parent or guardian)

Print: _____ Signed:_____Date:_____

THE SOURCE
CHIROPRACTIC

IF THIS HEALTH PROFILE IS FOR A MINOR/CHILD, PLEASE FILL OUT & SIGN

WRITTEN CONSENT FOR A CHILD/MINOR

NAME OF PATIENT WHO IS A CHILD / MINOR: _____

I AUTHORIZE THE SOURCE CHIROPRACTIC DOCTORS TO PERFORM A FUNCTIONAL EXAM, RENDER CHIROPRACTIC CARE AND PERFORM CHIROPRACTIC ADJUSTMENTS TO MY CHILD/MINOR.

AS OF THIS DATE, I HAVE LEGAL RIGHT TO SELECT AND AUTHORIZE HEALTH CARE SERVICES FOR MY CHILD/MINOR. IF MY AUTHORITY TO SELECT AND AUTHORIZE CARE IS REVOKED OR ALTERED, I WILL IMMEDIATELY NOTIFY THE SOURCE CHIROPRACTIC.

_____

Guardian Name Guardian Signature Date

_____ _____

Guardian Relationship to Child/Minor Witness Signature (Office Staff)