Pediatric Patient Introduction (0-3yrs)

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 Pitocin Other

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

_____

_____

_____

Child's birth weight: _____lbs. oz. Child's birth height: _____ in.
APGAR score at birth: APGAR score after 5 minutes:

Growth & Development History:

Is/was your child breastfed? Yes No If yes, how long? _____
Difficulty with breastfeeding? Yes No
Did they ever use formula? Yes No If yes, at what age? _____If yes, what type? _____

Did/does your child ever suffer from colic, reflux, or constipation as an infant? Yes No
If yes, please explain: _____

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

At what age did the child:
Respond to sound: _____ Follow an object: _____ Hold their head up:____ Vocalize: _____
Teethe: _____ Sit alone:_____ Crawl: _____ Walk: _____ Begin cow's milk:_____
Begin solid foods:
Does your Child seem to be developing typically for their age? _____

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

HEADACHES/MIGRAINES

ANTIBIOTICS

EAR INFECTIONS

GRATING OF NECK

DIFFICULT BREAST FEEDING

NECK PAIN/ STIFFNESS

TORTICOLLIS

COLIC

CHRONIC SINUS

THROAT ISSUES

SENSORY PROCESSING ISSUES

ASTHMA

TROUBLE EATING

ALLERGIES

ARM NUMBNESS

ARM PAIN

NIGHT TERRORS

SHOULDER PAIN

HEART DISORDERS

MID BACK PAIN

STOMACH DISORDERS

NAUSEA

REFLUX

KIDNEY PROBLEMS

BLADDER PROBLEMS

BED WETTING

SCIATICA

LEG NUMBNESS

FEET NUMBNESS

LOW BACK PAIN

HIP PAIN

LEG PAINS

KNEE PAIN

LIVER DISEASE

BOWEL PROBLEMS

TONGUE/LIP TIE

CHRONIC FATIGUE

RASHES

TROUBLE SLEEPING

ADD / ADHD

GERD

ANXIETY

NERVOUSNESS

EPILEPSY

AUTISM SPECTRUM DISORDER

VACCINE REACTION

OTHER_____

_____

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)