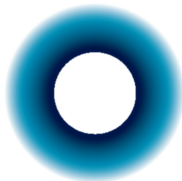

Family Chiropractic of Fairfax: A Creating Wellness Center

10831 Main St.
Fairfax, VA 22030

Tel (703) 273-7733
Fax (703) 385-9693
Website: familychiropracticoffairfax.com

PEDIATRIC

CONFIDENTIAL PATIENT INFORMATION

Date____/_____/_______

First Name_________________________M.I._____Last Name____

Address____

City____State_____________________Zip____________

E-Mail_____________________________Birthdate____/____/______Age____Sex M F SSN____-____-______

Father (full name)____
Home phone (____)_______________ Cell Phone (____)______________Work phone (____)______________

Mother (full name)____
Home phone (____)_______________ Cell Phone (____)______________Work phone (____)______________

Referred to this office by____

How do you prefer to be addressed: First Name Nickname____

ACCOUNT INFORMATION

PATIENT'S PRIMARY HEALTH INSURANCE

Policyholder's Name______________________________________DOB___/___/____SSN_____-____-_______

Insurance Company____Phone(_____)_________________

Address____

City____State__________________Zip____________

Policy No.______________________________________Group Name/No.________________________________

PATIENT'S SECONDARY HEALTH INSURANCE

Policyholder's Name______________________________________DOB___/___/_____ SSN_____-_____-_______

Insurance Company____Phone(_____)__________________

Address____

City____State__________________Zip____________

Policy No.______________________________________Group Name/No.________________________________

HEALTH INFORMATION

Has your child had previous chiropractic care? Y N Where?_______________________When?___________

Reason for seeking chiropractic care:____

How long has your child had this condition?_____________Were other doctors seen for this condition? Y N

Has your child had this or similar conditions in the past? Y N When?________________________________

Since this condition began, is it: Better_____ Worse_____ Unchanged_____

Other health problems____

Pediatrician's name, address, phone #____

____

Date of last visit ___ /___ /___ Reason____

Number of courses of antibiotics your child has taken:

During past 6 months________ Total during his/her lifetime________

Number of courses of other prescription medications your child has taken:

During past 6 months________ Total during his/her lifetime________

Vaccination history____

Has your child ever suffered from: (check all that apply)

___Dizziness	___Backaches	___Heart trouble	___Chronic earaches
___Diabetes	___Tuberculosis	___Hypertension	___Colds/Flu
___Juvenile arthritis	___Headaches	___Asthma	___Allergies
___Nerve pain	___Digestive disorders	___Sinus trouble	___Constipation
___Anemia	___Rheumatic fever	__Orthopedic problems	___Diarrhea
___Poor appetite	___Hyperactivity	___Sugar concentration	___Behavioral problems
___Bed wetting	___Convulsions	___Paralysis	___Muscle jerking
___Fainting	___Walking problems	___Broken bones	___Ruptures/Hernias
___Neck problems	___Arm problems	___Leg problems	___"Growing pains"
___Joint problems	___blood disorders	___Stomach aches	___Other____________

Childhood disease:

Chicken pox	Y	N	age_______	Mumps	Y	N	age_______
German measles	Y	N	age_______	Whooping cough	Y	N	age_______
Measles	Y	N	age_______	Other_____________			age_______

PRENATAL HISTORY

Type of Birth Attendant: OBGYN____CNM____Lay Midwife____Name of attendant:___________________________

Location of Birth: Homebirth___Birthing Center___Hospital____Other______________________________________

Complications during pregnancy: Y N Describe:____

Ultrasounds during pregnancy: Y N Number:_________

Medications during pregnancy/delivery: Y N List:____

Cigarette/Alcohol use during pregnancy: Y N

Birth interventions: Forceps____ Vacuum____ Caesarian: Planned____ or Emergency____
Complications during delivery: Y N Describe:____

Genetic disorders or disabilities: Y N Describe:____

Birth weight_______ Birth length________ APAR scores _______,________

FEEDING HISTORY

Breast Fed: Y N How long?_____________ Formula Fed: Y N How long?_____________

Type:__________________ cow's milk at____months, introduced solids at____months

Food/juice allergies or intolerances Y N Describe:____

DEVELOPMENTAL HISTORY

Number of hours sleeping per night:___________ Quality of sleep: Good_____ Fair_____ Poor_____

Type and age of mattress_____________________ Position your child sleeps in______________________

At what age was your child able to:

_____Respond to sound _____Sit up _____Stand alone
_____Hold head up _____Cross crawl _____Walk alone
_____Respond to visual stimuli

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e. from a bed or changing table, down stairs, etc.)

Was this the case with your child? Y N

When and how?____

List any jobs your child has had and when____

List any sports or physical activities your child participates in____

Has your child ever:

been knocked unconscious? Y N

used a cane, crutch, other support? Y N

been treated for a spine or nerve disorder? Y N

had any mental disorder? Y N

had any surgery? Y N

Describe___________________________

Does your child:

take any medications? Y N Type______________________

have any drug allergies? Y N Describe__________________

____

take vitamins or minerals? Y N Describe__________________

Has your child been involved in any motor vehicle accidents? Y N

When/describe?____

Has your child been seen on an emergency basis? Y N Reason(s) and Date(s): _________________________

____

____

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DOCTOR'S NOTES

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