WELCOME TO OUR OFFICE.

Hartley Chiropractic Center

WE THANK YOU FOR YOUR TRUST!

Pediatric Patient Application

Section 1: Patient Information **Appt.Date:**_____ **Referred By:**_____

Child's Name (First, Middle, Last):_____

☐ Male ☐ Female Date of Birth: _____/_____/_____ Age: _____

Address: _____ City: _____ Postal Code: _____

Home Phone: (____) _____ Cell Phone: (____) _____ Work Phone: (____) _____

Mother's Name: _____ Email Address: _____

Father's Name: _____

Section 2: Child's Current Problem

Purpose of this visit: _____Wellness Check-up _____Injury or Accident ____Other Please explain: _____

If your child is experiencing pain/discomfort, please identify where and for how long: _____

_____

1. When did the Problem first begin? Date _____/_____/_____ _____Unknown _____Gradual _____Sudden

2. Ever had this problem before? ____ No ____ Yes If yes, when? _____

3. Any bowel or bladder problems since this problem began? If yes, describe:_____

4. Have you seen any other doctors for this problem? ____No ____Yes If yes, who? _____

5. How long ago? _____Days _____ Weeks _____ Months _____Years

6. What were the results of past treatment? _____

7. How is this problem NOW: ☐Rapidly Improving ☐Improving Slowly ☐About the Same
☐Gradually Worsening ☐On & Off

8. Please list any medication taken for this problem: _____

9. Has your child ever sustained an injury playing organized sports? _____
If yes, please explain: _____

10. Has your child ever sustained an injury in an auto accident? _____
If yes, please explain: _____

Guardian's Signature: _____Date: _____/_____/_____

Doctor's Signature _____ Date Form Reviewed: _____/_____/_____

Section 3: Check any of the following conditions your child has suffered from during the past 6 months:

☐ Headaches	☐ Poor Appetite	☐ Diarrhea	☐ Fall from crib	☐ Fall from bed or couch
☐ Digestive Disorders	☐ Stomach Aches	☐ Backaches	☐ Allergies	☐ Fall down stairs
☐ Behavioral Problems	☐ Arm Problems	☐ Hypertension	☐ Chronic Colds	☐ Fall in walker
☐ Dizziness	☐ Reflux	☐ Asthma	☐ Temper Tantrums	☐ Fall from changing table
☐ Neck Problems	☐ Fainting	☐ Anemia	☐ Sleeping Problems	☐ Fall off monkey bars
☐ Ear Infections	☐ Muscle Pain	☐ Scoliosis	☐ Colic	☐ Fall off skateboard/skates
	☐ Leg Problems	☐ Bed Wetting	☐ Fall off slide	
	☐ Heart Trouble	☐ Walking Trouble	☐ Fall from high chair	
	☐ Constipation	☐ Poor Posture		

Notes _____

Section 4: Prenatal History

Name of Obstetrician / Midwife: _____

Complications during pregnancy? ____No ____Yes, list: _____

Ultrasounds during pregnancy? ____No ____Yes, number: _____

Medications during pregnancy/delivery?_____ No ____Yes, list:_____

Cigarette /Alcohol use during pregnancy: ____No ____Yes

Birth Weight: _____ Birth Length: _____

Location of Birth: ____Hospital ____Birthing Center ____Home

Birth Intervention: ____Forceps ____Vacuum Extraction ____Caesarian Section, Emergency or Planned?

Complications during delivery? ____No ____Yes, list: _____

Genetic disorders or disabilities? ____No ____Yes, list: _____

Section 5: Infancy

Name of Pediatrician: _____

Date of Last Visit:____ /____ /_____ Reason: _____

Number of doses of antibiotics your child has taken:

During the past six months:_____ Total during his/her lifetime:____

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

During the past six months:_____ Total during his/her lifetime: _____ List: _____

Vaccination History: _____

Feeding History:

Breast Fed: ____No ____Yes, how long: _____

Formula Fed:____ No ____Yes, how long: _____ Type: _____

Introduced to solids at: _____Month, Cows' Milk at _____Months

Food/Juice allergies or intolerances: ____No ____Yes, list: _____

I herby authorize Elevation Health and its Doctors to administer care to my Son/Daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Guardian's Signature: _____Date: _____/_____/_____

Doctor's Signature _____ Date Form Reviewed: _____/_____/_____