Pediatric Entrance Form

(Please Print) Date: _____

Name: _____SS:_____Home Phone Number: _____

Address: _____City:_____State:_____Zip:_____

Date of Birth: _____Age: _____Sex: M F

How were you referred to our office?_____

Have you ever been to a chiropractor before? _____ If so, when? _____

Reason for consulting this office: _____ Specific problem or symptom?

_____ Preventing illness or disease?

_____Maximizing health potential?

Birth

Location_____, Medications_____, Length _____Weight_____,

C-Section_____, Pulling on Head_____, Forceps or vacuum _____

Labor Complications_____

Medical History

Vaccinations: _____

Medications: _____

Past Illness: _____

Breast Fed: _____

Sleeping Habits: _____

Traumas (Slips, Falls, Accidents):_____

Problem History

Check All That Apply

____Allergies	_____Diarrhea	_____Joint Stiffness
____Asthma	_____Ear Infection (Hearing Problems)	_____Kidney Problems
_____Breathing Problems (ex. Bronchitis)	_____Epilepsy	_____Mononucleosis
_____Bed Wetting	_____Eye Problems	_____Menstrual Problems
____Bleeding (nose bleeds)	_____Fever	_____Sore Throat
_____Constipation	_____Hyperactivity	_____Speech Difficulty
_____Coughing	_____Headaches	_____Tonsillitis
____Digestion Problems	_____Jaundice	_____Vomiting

Other Problems:_____

List other doctors consulted for these conditions:

1._____

2._____

Today's services will be handled by: Cash_____ Check_____ Visa/MC_____

Parents Signature_____ Date _____