PEDIATRIC PATIENT INFORMATION

Please answer each of the following questions as completely as possible.

Name:_____ **Date of Birth:**____/____/_____ ☐ **Male** ☐ **Female**
Address:_____ **City:**_____ **State:**____ **Zip:**_____
Parent E-mail Address: _____ **Soc. Sec. #:**_____
Cell Ph:_____ **Home Ph:**_____ **Work Ph:**_____
Parent / Guardian Name:_____ **Referred By:**_____
Number of Other Children in Family:_____ **Birth Order of Patient:** _____

1. Presenting Concerns

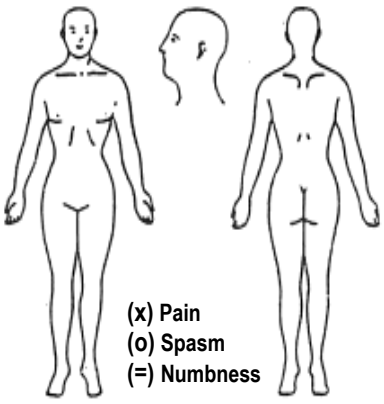
Complete below as detailed as Possible

Describe the specific reason(s) for your child's visit today. . .

*1.*_____
*2.*_____
*3.*_____

Important! Mark the location, quality and the severity, of your child's complaint(s).

Location



Quality

☐ Ache
☐ Sharp
☐ Throb
☐ Burn
☐ Numb
☐ Tingle
☐ Radiating
☐ Swollen
☐ Spasm
☐ Stiff
☐ Weak
☐ Other

Severity

Low
1 ☐
2 ☐
3 ☐
4 ☐
5 ☐
6 ☐
7 ☐
8 ☐
9 ☐
0 ☐
High

How often does child experience these concerns?
☐ Constant ☐ Frequently ☐ Occasionally

Describe the health concern that prompted this visit? _____

How has concern(s) changed since onset? ☐ Better ☐ Worse ☐ Remaining the Same

What caused the above concern(s)? _____

What currently aggravates concern(s)? _____

What seems to improve concern(s)? _____

Has patient experienced previous episodes of this condition? ☐ No ☐ Yes When? _____

Have they seen other doctors for the above? ☐ No ☐ Yes Who? _____

What was diagnosis? _____ What was recommended? _____

2. Activities & Lifestyle

Does this interfere with school or daily activities? ☐ No ☐ Yes How? _____
Does this affect social / family activities? ☐ No ☐ Yes How?_____
Does this affect child's sleep? ☐ No ☐ Yes How? _____
How is your child's appetite / eating habits? ☐ Always Hungry ☐ Seldom Hungry ☐ Picky / Finicky Eater

3. Environmental Stressors

What are child's daily activities/ requirements (e.g.: school, chores, playing, etc.) _____
How many hours / day is spent on ☐ school (___) ☐ computer (___) ☐ phone (___) ☐ athletics/play (___) ☐ TV (___)
Does the patient currently take any medications for **this** complaint? ☐ No ☐ Yes What?_____
Does patient exercise, workout, or play sports? ☐ Not at all ☐ Regularly ☐ Periodically What? _____

Please Complete Other Side. . .

4. Your Past Health History

Please **check (✓) any health issues that your child has experienced:**

- ☐ Low Back Pain
- ☐ Middle Back Pain
- ☐ Neck Pain
- ☐ Hip / Leg Pain
- ☐ Joint Pain
- ☐ Shoulder /Arm Pain
- ☐ Headaches
- ☐ Sleep Disorders
- ☐ Weak Muscles
- ☐ Urinary Problems
- ☐ Weight Loss / Gain
- ☐ Mood swings
- ☐ Nervousness
- ☐ Throat / Voice
- ☐ Numbness
- ☐ Dizziness
- ☐ Seizures
- ☐ Shaking/Tremors
- ☐ Coughing or Wheezing
- ☐ Excessive Thirst
- ☐ Genital Pain
- ☐ Heartburn
- ☐ Eyes / Vision
- ☐ Ears / Hearing
- ☐ Sinus Pain / Drainage
- ☐ Blood Pressure
- ☐ Cold Hands / Feet
- ☐ Poor Circulation
- ☐ Chest Pain
- ☐ Lungs/Breathing
- ☐ Dental / TMJ
- ☐ Nausea
- ☐ Diarrhea
- ☐ Constipation

Female Only

- ☐ Menstrual Problems
- ☐ Back Pain w/ Period
- ☐ Birth Control Pills
- ☐ Breast Lumps
- ☐ Breast Implants
- ☐ Breast Pain

Is there any possibility of pregnancy? ☐Yes ☐No

Has child suffered any previous traumas / injuries? ☐No ☐Yes
Has child been in an automobile accident? ☐No ☐Yes
Has child had any previous surgeries? ☐No ☐Yes
Has child had any joint injuries or broken bones? ☐No ☐Yes

5. Your Family Health History

Is there a family history of: ☐ Cancer ☐ Diabetes ☐ Heart or Stroke ☐ Lung ☐ Obesity ☐ Other: _____
Has anyone in your family expressed similar health concerns as those for which we are being consulted? ☐No ☐Yes
Are you concerned about the health of any member of your family for any reason? ☐No ☐Yes

6. Your General Health

	No	Yes	Please Explain:
Has child missed school in the past year due to a health issue?	☐	☐	_____
Does your child experience a cold or the flu more than once a year?	☐	☐	_____
Does child regularly use any medications for pain?	☐	☐	_____
Does your child take vitamins regularly?	☐	☐	_____

How well does your child deal with stress?	☐ Excellent	☐ Good	☐ Poor	☐ Unsure
Overall, how is your child's diet?	☐ Excellent	☐ Good	☐ Poor	☐ Unsure
How are your child's energy levels?	☐ Hyperactive	☐ Normal	☐ Fatigued	☐ Unsure
How do you feel your child's posture is?	☐ Excellent	☐ Good	☐ Poor	☐ Unsure
How is child's attitude towards life?	☐ Excellent	☐ Good	☐ Poor	☐ Unsure
How restfully does your child sleep?	☐ Excellent	☐ Good	☐ Poor	☐ Unsure
How many hours of sleep / night:	☐ 0-4 hours	☐ 5-8 hours	☐ more than 8 hours	

How would you rate your child's overall health today compared to one year ago? ☐ Same ☐ Better ☐ Worse

Please mark the appropriate circle:

In general, how would you rate your child's overall health & vitality?

(Low) ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ (High)

In general how would you rate your child's levels of daily stress?

At School: (Low) ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ (High)

At home: (Low) ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ (High)

Our recommendations for your child's care are always based on **your** health objectives. What best describes your current objectives?

- ☐ **Relief Care** - I only want symptom relief. I am not interested in improving my child's health or the correction of "cause".
- ☐ **Corrective Care** - I am interested in correcting the causes of my child's health concerns and rebuilding strength and vitality.
- ☐ **Health / Wellness Care** – I am interested in improving and maintaining my child's health and normal development.

I understand that my care in this office involves the making of judgements that are based upon the facts known by the doctor. Therfore, the above information is true and complete to the best of my knowledge. I also verify that I am not seeking care for any worker's comp, automobile accident, or third party pay injury. I hereby authorize the release of all HIPAA protected health information to my personal insurance carrier or to any party who may become liable for this care. I hereby request and give permission for this office to examine, evaluate, and render chiropractic care for the above mentioned health concerns.

_____ _____
Patient / Guardian Signature *Date*