



# PEDIATRIC PATIENT INTRODUCTION CARD

Date: \_\_\_\_\_

Child's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: M F

Street Address: \_\_\_\_\_ City, ST, Zip: \_\_\_\_\_

Parent's Names: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

Reason for coming to our office: \_\_\_\_\_

Name of Person Responsible for the Account: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Preferred Phone #: \_\_\_\_\_

Address (if different than above): \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Name of Insured: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

## *Present Health Challenge(s)*

For what health challenge(s) is your child here for? When did it begin?  
\_\_\_\_\_

Has your child seen other health care practitioners for this? What did they recommend?  
\_\_\_\_\_

What was the outcome of prior treatment/recommendations?  
\_\_\_\_\_

Is this dysfunction getting progressively worse? \_\_\_ Yes \_\_\_ No

## *Health History*

**Symptoms:** Please check any current or past problems your child has on the list below:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Anemia              | <input type="checkbox"/> Constipation       | <input type="checkbox"/> Insomnia           |
| <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Convulsions        | <input type="checkbox"/> Itchy Eyes         |
| <input type="checkbox"/> ADHD                | <input type="checkbox"/> Cough/Wheeze       | <input type="checkbox"/> Knee/Foot Pain     |
| <input type="checkbox"/> Allergies           | <input type="checkbox"/> Diabetes           | <input type="checkbox"/> Leg/Hip Pain       |
| <input type="checkbox"/> Anxiety             | <input type="checkbox"/> Diarrhea           | <input type="checkbox"/> Muscle Pain        |
| <input type="checkbox"/> Arm/Elbow Pain      | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Neck Pain          |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Dizziness          | <input type="checkbox"/> Nightmares         |
| <input type="checkbox"/> Autism              | <input type="checkbox"/> Eczema             | <input type="checkbox"/> Poor Appetite      |
| <input type="checkbox"/> Backaches           | <input type="checkbox"/> Fainting           | <input type="checkbox"/> Poor Memory        |
| <input type="checkbox"/> Behavioral Issues   | <input type="checkbox"/> Fever/Chills       | <input type="checkbox"/> Rashes             |
| <input type="checkbox"/> Bed Wetting         | <input type="checkbox"/> Frequent Colds     | <input type="checkbox"/> Reflux/Spitting up |
| <input type="checkbox"/> Blood disorders     | <input type="checkbox"/> Growing pains      | <input type="checkbox"/> Runny Nose         |
| <input type="checkbox"/> Broken bones: _____ | <input type="checkbox"/> Headaches          | <input type="checkbox"/> Scoliosis          |
| <input type="checkbox"/> Chest Pain          | <input type="checkbox"/> Heart Condition    | <input type="checkbox"/> Sinus Trouble      |
| <input type="checkbox"/> Chronic Earaches    | <input type="checkbox"/> Hernias            | <input type="checkbox"/> Sprains/Strains    |
| <input type="checkbox"/> Colic               | <input type="checkbox"/> Hyperactivity      | <input type="checkbox"/> Stomach Aches      |
| <input type="checkbox"/> Concussions         | <input type="checkbox"/> Hypertension       | <input type="checkbox"/> Unusual Moles      |
|  | <input type="checkbox"/> Joint Pain         | <input type="checkbox"/> Other _____        |

Name of Pediatrician: \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_

Current Medications & Vitamins: \_\_\_\_\_

Past Trauma (falls, sports injuries, accidents, etc) \_\_\_\_\_

Past Surgeries: \_\_\_\_\_

**Prenatal History**

Location of Birth: \_\_\_ Home \_\_\_ Birthing Center \_\_\_ Hospital

Complications during pregnancy: Y - N List: \_\_\_\_\_

Medications during pregnancy/delivery: \_\_\_\_\_

Cigarette / Alcohol use during pregnancy: Y - N

Birth intervention: \_\_\_ Forceps \_\_\_ Vacuum \_\_\_ Caesarian

Complications during delivery: Y - N List: \_\_\_\_\_

Birth weight \_\_\_\_\_ Birth length \_\_\_\_\_

**Feeding history**

Breast Fed: Y - N How long'? \_\_\_\_\_ Formula fed: Y - N How long'? \_\_\_\_\_ Type: \_\_\_\_\_

Introduced to cereal at \_\_\_\_\_ months. Solids at \_\_\_\_\_ months. Cow's milk at \_\_\_\_\_ months

Food / juice allergies or intolerances Y - N List: \_\_\_\_\_

**Developmental History**

Sleep (Hrs per night) \_\_\_\_\_ Problems sleeping \_\_\_\_\_

**Medical/Vaccination History**

Has your child ever had an adverse reaction to a prescription or over-the-counter medication? Y - N

If yes, please

explain: \_\_\_\_\_

Has your child been vaccinated? Y - N Adverse reactions to any

vaccine? \_\_\_\_\_

**Childhood Diseases**

\_\_\_ Chicken Pox : Age \_\_\_\_\_ \* \_\_\_ Mumps: Age \_\_\_\_\_ \* \_\_\_ Rubella: Age \_\_\_\_\_ \* \_\_\_ Whooping cough: Age \_\_\_\_\_

\_\_\_ Measles: Age \_\_\_\_\_ \* \_\_\_ Meningitis: Age \_\_\_\_\_ \* \_\_\_ Tuberculosis: Age \_\_\_\_\_ \* \_\_\_ Other: Age \_\_\_\_\_

**CONSENT FOR TREATMENT OF MINOR**

I hereby certify that the information I have provided is correct and accurate, to the best of my knowledge.

I, \_\_\_\_\_, as the parent/guardian of this child, \_\_\_\_\_, hereby grant permission for my child to receive examination and chiropractic treatment as deemed necessary.

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date