GREATER ROCHESTER CHIROPRACTIC

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CONFIDENTIAL PEDIATRIC PATIENT INFORMATION

Child's Name: ______________________________________ Date: _______________________

Gender: M / F Date of Birth: _____ / _____ / _____ Age: _____ Grade in school: _____

Home Phone: (___) ________________ Social Security #: __________________

Parent's E-mail Address: ____ (optional-for appointment reminders)

Address: ______________________________ City: ______________________ State: _____ ZIP: ________

Mother's Name: _____________________ Cell/Work Phone: _______________________________

Father's Name: ______________________ Cell/Work Phone: _______________________________

Purpose of this appointment: ____

Pediatrician: _______________________________________ Phone: _________________________

Pregnancy History

(If the child is adopted, answer to the best of your ability.)

Select any of the following you experienced during your pregnancy:

- ❍ Severe viral infection during the first trimester
- ❍ Breech position during pregnancy
- ❍ Accident or Infections
- ❍ Smoking
- ❍ Severe stress
- ❍ Pre-eclampsia
- ❍ Alcohol consumption and/or drug use
- ❍ Radiation exposure
- ❍ Hypertension (high blood pressure)
- ❍ Toxoplasmosis
- ❍ Uncontrolled Diabetes
- ❍ Toxemia

Labor and Delivery History

Select any of the following you and/or the child experienced during labor/delivery:

- ❍ Hospital Birth
- ❍ Birthing Home
- ❍ Long and/or difficult labor
- ❍ Placenta Previa
- ❍ Forceps or suction cups used
- ❍ Fetal Distress
- ❍ Elective C-section
- ❍ Child was a "blue baby"
- ❍ Home Birth
- ❍ Induced labor
- ❍ Rapid delivery
- ❍ Breech Birth
- ❍ Cord around the neck
- ❍ Emergency C-section
- ❍ Premature delivery (2+ weeks)

Comments:

____

____

Newborn History

Select any of the following that your child experienced as a newborn:

- ❍ Required resuscitation/oxygen
- ❍ Prolonged jaundice
- ❍ Poor sleeper
- ❍ Immunizations in hospital

  If yes, please specify vaccine: _________________

  ____

- ❍ Distorted skull
- ❍ Difficulty latching/sucking
- ❍ Formula fed
- ❍ Breast fed
- ❍ Bottle fed
- ❍ Colic

Weight at birth: __________

Length at birth: __________

Health History

Select any of the following that your child has experienced or been diagnosed with:

- ❍ Illnesses accompanied by a high fever
- ❍ Frequent Headaches
- ❍ Seizures/Convulsions
- ❍ Chronic ear infections/earaches
- ❍ Head injury
- ❍ Serious fall(s) or repetitive falls
- ❍ Epilepsy
- ❍ Meningitis
- ❍ Allergies to foods
- ❍ Environmental allergies
- ❍ Chemical sensitivities
- ❍ Surgery
- ❍ Neck or back problems
- ❍ Adverse reaction to any vaccinations (even if mild)

  If yes, please explain: _________________________

- ❍ Dizziness
- ❍ Diabetes
- ❍ Hypoglycemia (low blood sugar)
- ❍ Trouble with bladder control (enuresis)
- ❍ Fainting
- ❍ High blood pressure
- ❍ Heart Disease
- ❍ Asthma
- ❍ Sinus problems
- ❍ Constipation
- ❍ Diarrhea
- ❍ Digestive disorders
- ❍ Rheumatic Fever
- ❍ Joint or muscle problems

Developmental History

Select all that apply or did apply:

- ❍ Difficulty crawling (on all fours)
- ❍ Difficulty learning to ride a bike
- ❍ Difficulty learning to read
- ❍ Difficulty using utensils
- ❍ Difficulty tying shoes
- ❍ Poor hand-eye coordination
- ❍ Did not crawl on all fours
- ❍ Appears clumsy
- ❍ Difficulty with writing
- ❍ Difficulty buttoning clothes
- ❍ Difficult or awkward with walking/running
- ❍ Difficulty sitting still or paying attention.
- ❍ Age that your child started to walk unassisted: _______________

Comments: ____

Neurological/Other

Has your child ever been diagnosed by a medical professional with any of the following? If yes, by whom?

- ❍ Hearing loss or impairment
- ❍ Visual Impairment
- ❍ Neurological disorders
- ❍ Anxiety/Depression requiring treatment
- ❍ Obsessive Compulsive Disorder (OCD)
- ❍ Autism/Autism Spectrum Disorder
- ❍ ADD/ADHD
- ❍ Tourette's Syndrome
- ❍ Dyslexia
- ❍ Other _________________________________

Current/Past Medications and Treatments

List any medications your child is taking:
(List names, dosage and frequency)

____

____

List any special dietary needs that your child has:

____

____

List any supplements your child takes:

____

____

____

List any treatment that your child is currently undergoing with any health professional:

____

____

List any special services that your child is currently receiving at school or privately:

____

____

____

List any previous chiropractic treatment, medications, or other medical treatment that your child has undergone:

____

____

____

Main Condition/Symptoms: ____

Other conditions/symptoms: ____

How long has your child had these conditions/symptoms?: _______________________________

Height: ___feet ___inches Weight: ____ Last know blood pressure: ___/___ Hypertension: ___Yes ___No

Surgeries: ____ Approx. dates: ____________________________

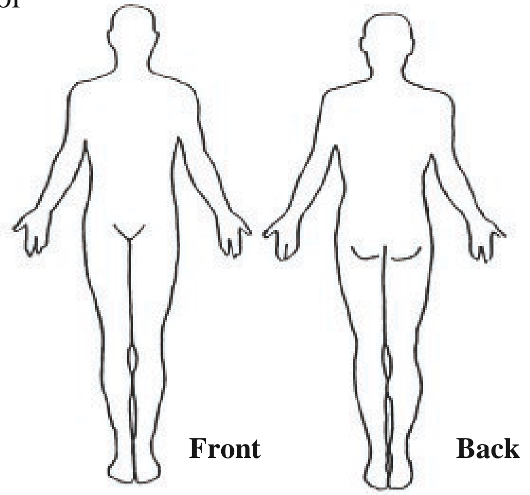
Hospitalizations: _______________________________________ Approx. dates: ____________________________

Major Illnesses: ____ Approx. dates: ____________________________

Diabetes: ___ Yes* ___ No *If yes: ___Type I ___Type II

CURRENT COMPLAINTS

On the diagram, please indicate the location of pain and the symbol that best describes what your child is currently experiencing:



SHARP/STABBING † † † †

DULL/ACHEY V V V V

PINS/NEEDLES 0 0 0 0

NUMBNESS / / / / /

Does your child have pain every day? ___Yes ___No

Does your child's pain wake you at night? ___Yes ___ No

Are your child's symptoms: ___Worsening ___Unchanged ___Improving

What increases your child's pain?

____

What decreases your child's pain?

____

Has your child seen other doctors for this condition? If so, who?: ____________________________________

Date of last physical exam: ____________ Date of last spinal X-RAYs/MRIs : _________ _________

Have you had previous chiropractic care: ___YES ___NO

AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize ____________________________, D.C. to evaluate and treat my son/daughter as he/she deems necessary.

I acknowledge that I am financially responsible for any and all fees charged by Greater Rochester Chiropractic and the payment will be made as soon as services are provided.

Parent or Legal Representative's Name: _______________________________ Relationship: ______________
(please print)

Patient or Legal Representative's Signature: __________________________________ Date: _______________