PEDIATRIC INFORMATION

This information will be strictly confidential. Please print neatly, fill out completely, and be as accurate as possible.

Patient Information

Patient Name: ____________ Social Security Number: ____________
Name of Parent/Guardian: ____________ E-mail Address: ____________
Address: ____________
City: ____________ State: ____________ Zip: ____________
Home Telephone: Parent Work Telephone: ____________
Birth date: ________ Sex: ∟M ∟F Weight: ________ Height: ________
Number siblings: ________
How did you hear about our office or who referred you?

Insurance Information

Do you have medical insurance? ☐Yes ☐No Insurance company name: ____________
Policy number: ____________ Insurance company telephone: ____________
Insured's name: ____________ Relationship to patient: ____________
Insured's birth date: ____________ Insured's Social Security Number ____________
Insured's Employer Insured's Employee Address

Chiropractic History

Reason for seeking chiropractic care: ____________
Other doctors seen for this condition: ☐Yes ☐No
Other health problems ____________
Previous Chiropractor: ____________ Date of last visit: ____________
Reason for treatment:

Health History

Has your child ever suffered from: (check all that apply)

☐Dizziness	☐Neck problems	☐Convulsions	☐Orthopedic problems	☐Allergies
☐Diabetes	☐Joint problems	☐Walking problems	☐Sugar concentration	☐Constipation
☐Arthritis	☐Back aches	☐Arm problems	☐Paralysis	☐Diarrhea
☐Neuritis	☐Tuberculosis	☐Blood disorders	☐Broken bones	☐Behavioral problems
☐Anemia	☐Headaches	☐Heart trouble	☐Leg problems	☐Muscle jerking
☐Poor appetite	☐Digestive disorders	☐Hypertension	☐Stomach aches	☐Ruptures/hernias
☐Bed wetting	☐Rheumatic fever	☐Asthma	☐Chronic earaches	☐ "Growing pains"
☐Fainting	☐Hyperactivity	☐Sinus trouble	☐Colds/flu	☐Other:

Family health history: ____________
Name of Pediatrician: ____________ Date of last visit: ____________
Reason for treatment: ____________
Are you satisfied with the care your child received there? ☐Yes ☐No
Number of doses of antibiotics your child has taken: ________ During last 6 months: ____________
Total during his/her lifetime: ________
Number of doses of other prescription medications your child has taken: ____________
During the last 6 months: ____________
Total during his/her lifetime: ____________
Vaccination history: ____________