

# PEDIATRIC PATIENT INTRODUCTION

CHILD'S NAME: \_\_\_\_\_ MOTHER'S NAME: \_\_\_\_\_  
LAST FIRST MIDDLE LAST FIRST MIDDLE

CASE NUMBER: \_\_\_\_\_ FATHER'S NAME: \_\_\_\_\_  
LAST FIRST MIDDLE

ADDRESS: \_\_\_\_\_ CITY/TOWN: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ MOTHER'S WORK PHONE: \_\_\_\_\_ FATHER'S WORK PHONE: \_\_\_\_\_

BIRTH DATE: \_\_\_\_\_ AGE: \_\_\_\_\_ BIRTH WEIGHT: \_\_\_\_\_ CURRENT WEIGHT: \_\_\_\_\_

SEX: \_\_\_\_\_ NO. OF SIBLINGS: \_\_\_\_\_ BIRTH LENGTH: \_\_\_\_\_ CURRENT LENGTH: \_\_\_\_\_

TYPE OF BIRTH: NORMAL VAGINAL \_\_\_\_\_ FORCEPS \_\_\_\_\_ BREECH \_\_\_\_\_ CESAREAN \_\_\_\_\_

HOME: \_\_\_\_\_ BIRTHING CENTER: \_\_\_\_\_ HOSPITAL: \_\_\_\_\_

PROBLEMS DURING PREGNANCY: \_\_\_\_\_

PROBLEMS DURING LABOR / DELIVERY: \_\_\_\_\_

APGAR SCORES: \_\_\_\_\_ WAS THERE PRESENCE AT BIRTH OF: \_\_\_\_\_ JAUNDICE (YELLOW)  
\_\_\_\_\_ CYANOSIS (BLUE)

CONGENITAL ANOMALIES / DEFECTS: \_\_\_\_\_

INFANT FEEDING: BREAST \_\_\_\_\_ BOTTLE \_\_\_\_\_ FORMULA \_\_\_\_\_

NO. OF HOURS SLEEP PER NIGHT: \_\_\_\_\_ QUALITY OF SLEEP: GOOD \_\_\_\_\_ FAIR \_\_\_\_\_ POOR \_\_\_\_\_

OBSTETRICIAN / MIDWIFE: \_\_\_\_\_  
NAME LOCATED AT

PEDIATRICIAN / FAMILY MD: \_\_\_\_\_  
NAME LOCATED AT

DATE OF LAST VISIT TO MD: \_\_\_\_\_ PURPOSE: \_\_\_\_\_

IMMUNIZATION HISTORY: \_\_\_\_\_

PURPOSE OF THIS APPOINTMENT: \_\_\_\_\_

HAS YOUR CHILD EVER BEEN TREATED ON AN EMERGENCY BASIS?: \_\_\_\_\_

DESCRIBE: \_\_\_\_\_

INSURANCE/BILLING INFORMATION: \_\_\_\_\_ POLICY #: \_\_\_\_\_

## AUTHORIZATION FOR CARE OF MINOR

I HEREBY AUTHORIZE THIS CLINIC AND IT'S DOCTOR(S) TO ADMINISTER CARE AS THEY SO DEEM NECESSARY TO MY SON / DAUGHTER / WARD (UPON APPROVAL OF PARENT OR GUARDIAN)

SIGNED: \_\_\_\_\_ WITNESSED: \_\_\_\_\_ DATE: \_\_\_\_\_

I REALIZE THAT I AM RESPONSIBLE FOR ALL FEES CHARGED BY THIS CLINIC AND THAT I WILL PAY FOR ALL SERVICES AS THEY ARE PERFORMED. X-RAYS REMAIN THE PROPERTY OF THIS CLINIC.

DATE: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_

# PEDIATRIC CASE HISTORY

PREGNANCY HISTORY: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

DELIVERY / BIRTH HISTORY: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

DEVELOPMENTAL HISTORY: AT WHAT AGE DID THE CHILD:  
\_\_\_\_\_ RESPOND TO SOUND \_\_\_\_\_ CRAWL  
\_\_\_\_\_ FOLLOW AN OBJECT WITH HIS/HER EYES \_\_\_\_\_ STAND  
\_\_\_\_\_ HOLD HEAD UP \_\_\_\_\_ WALK ALONE  
\_\_\_\_\_ SIT ALONE \_\_\_\_\_

CHILDHOOD DISEASES: \_\_\_\_\_ CHICKENPOX \_\_\_\_\_ RUBELLA  
\_\_\_\_\_ MUMPS \_\_\_\_\_ RUBEOLA  
\_\_\_\_\_ MEASLES \_\_\_\_\_ WHOOPING COUGH  
OTHER: \_\_\_\_\_

HAS THIS CHILD EVER SUFFERED FROM:

<input type="checkbox"/> Dizziness	<input type="checkbox"/> Backaches	<input type="checkbox"/> Heart Trouble	<input type="checkbox"/> Chronic Earaches
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Colds/Flu
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Headaches	<input type="checkbox"/> Asthma	<input type="checkbox"/> Allergies
<input type="checkbox"/> Neuritis	<input type="checkbox"/> Digestive Disorders	<input type="checkbox"/> Sinus Trouble	<input type="checkbox"/> Constipation
<input type="checkbox"/> Anemia	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Orthopedic Problems	<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Poor Appetite	<input type="checkbox"/> Hyperactivity	<input type="checkbox"/> Sugar Concentration	<input type="checkbox"/> Behavioral Problems
<input type="checkbox"/> Bed Wetting	<input type="checkbox"/> Convulsions	<input type="checkbox"/> Paralysis	<input type="checkbox"/> Muscle Jerking
<input type="checkbox"/> Fainting	<input type="checkbox"/> Walking Problems	<input type="checkbox"/> Broken Bones	<input type="checkbox"/> Ruptures / Hernias
<input type="checkbox"/> Neck Problems	<input type="checkbox"/> Arm Problems	<input type="checkbox"/> Leg Problems	<input type="checkbox"/> "Growing Pains"
<input type="checkbox"/> Joint Problems	<input type="checkbox"/> Blood Disorders	<input type="checkbox"/> Stomach Aches	<input type="checkbox"/> Other

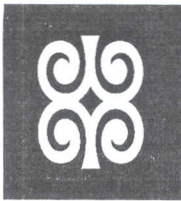
PRESENT HISTORY: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

SURGERY: \_\_\_\_\_

MEDICATIONS: \_\_\_\_\_

ACCIDENTS: \_\_\_\_\_

FAMILY HISTORY: \_\_\_\_\_



# Anderson Chiropractic

Susan A. Anderson, D.C.

1395 Jordan St., Suite D

North Liberty, IA 52317

## Consent to treat a minor child

I hereby authorize:

Dr Susan Anderson, D.C. and whomever he or she may designate as assistants to administer chiropractic care as deemed necessary to

My \_\_\_\_\_  
(indicate relationship of child)

\_\_\_\_\_  
(Name of child)

Dated at North Liberty, IA this \_\_\_\_\_ day of \_\_\_\_\_ 20.

Signed \_\_\_\_\_

Witnessed \_\_\_\_\_