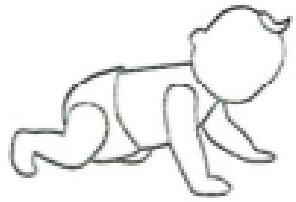
Bauer CHIROPRACTIC

Pediatric



History of Present Concerns

Child's Name: _____ **Age:** _____ **Date of Birth:** _____ **Sex:** M F

Street Address: _____

City, ST, Zip: _____

Parent's Names: _____

Phone: _____ **Email:** _____

Who may we thank fo referring you to our office? _____

Reason for coming Into the office: _____

Name of Person Responsible for the Account: _____

Relationship to Patient: _____ **Preferred Phone #:** _____

Address: (if different from above): _____

Insurance Company: _____ **Name of Insured:** _____

Relationship to Patient: _____ **Date of Birth:** _____

Present Health Concern(s)

For what health concern(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?

_____

Health History:

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

___ Anemia
___ Arthritis
___ ADHD
___ Allergies
___ Anxiety
___ Arm/Elbow Pain
___ Asthma
___ Backaches
___ Behavioral Issues
___ Bed Wetting
___ Blood Disorders
___ Broken Bones: _____
___ Chest Pain
___ Chronic Earaches
___ Colic
___ Concussions
___ Constipation
___ Convulsions
___ Cough/Wheeze
___ Diabetes
___ Diarrhea
___ Digestive Problems
___ Dizziness
___ Eczema
___ Fainting
___ Fever/Chills
___ Frequent Colds
___ Growing Pains
___ Headaches
___ Heart Condition
___ Hernias
___ Hyperactivity
___ Hypertension
___ Joint Pain
___ Insomnia
___ Itchy Eyes
___ Knee/Foot Pain
___ Leg/Hip Pain
___ Muscle Pain
___ Nightmares
___ Poor Appetite
___ Rashes
___ Reflux/Spitting Up
___ Runny Nose
___ Scoliosis
___ Sinus Trouble
___ Sprains/Strains
___ Stomach Aches
___ Unusual Moles
___ Other: _____

Name of Pediatrician: _____ Date of Last Visit: _____

Current Medications & Vitamins: _____

Past Trauma (falls, accidents, ect): _____

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: _____

Developmetal History:

Sleep (hrs per night) _____ Problems sleeping: _____

Medical/Vaccination History

Has your child ever had an adverse reactions to a prescription or over-the-counter medications?

Y - N

If yes, please explain: _____

Has your child been vaccinated? Y - N

Adverse reactions to any vaccine? _____

Childhood Diseases

___ Chicken Pox : Age _____

___ Measles : Age _____

___ Meningitis : Age _____

___ Mumps : Age _____

___ Rubella : Age _____

___ Tuberculosis : Age _____

___ Whooping Cough : 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 neccessary.

_____ _____

Signature of Parent or Guardian Date