Pediatric Patient Information

Date: _____/_____/_____

Patient Name: _____ Sex: Male / Female Age: ____ Birth Date: ____/____/____
Address: _____ City:_____ State:_____ ZIP:_____
Child's SS#: _____ Family Email Address: _____
Mother's Name: _____ Phone# (Home) _____ (Cell)_____
Occupation: _____ Work Phone# _____
Father's Name: _____ Phone# (Home) _____ (Cell)_____
Occupation: _____ Work Phone# _____
Legal Guardian:_____Relationship to child: _____
Siblings and ages: _____
How did you hear about our office or whom may we thank for referring you to us? _____

Describe Reason(s) for appointment today, beginning with highest priority: If No health concerns write "Wellness Checkup"
(Wellness checkups are not covered by insurance companies.)

1. _____ 2. _____
3. _____ 4. _____

Other Doctor(s) names seen for conditions: _____
Prior Treatments: _____
Past Heath History Problems: _____

Chiropractor(s) have seen before: _____

Past Surgeries: Y N List: _____
Number of Doses of Antibiotics in Life: ____ Number of Doses of Other Prescription Medications in Life: _____
Current Medications: _____
Past Medications: _____
Vaccination History: _____ Reactions? Yes No _____

Prenatal and Birth History:

Obstetrician/ Midwife: _____ Pediatrician/M.D.: _____
Pregnancy Problems? Y N List: _____
Ultrasounds During Pregnancy? Y N Number: _____ Cigarette/ Alcohol Use During Pregnancy: Y N
Medications During Pregnancy / Delivery? Y N List: _____
Location of Birth: Hospital / Birthing Center / Home
Birth: Normal Vaginal / Emergency C-Section / Planned C-Section / Breech / Medication / Epidural / Forceps / Vacuum Extraction Labor/Delivery Problems: _____
Genetic Disorders or Disabilities: Y N List: _____
Was there presence at birth: Jaundice (yellow) Cyanosis (blue/lack of oxygen) Meconium (black/green infant feces) APGAR Score: _____
Birth Weight: _____ Length: _____ Present Weight: _____ Length: _____

Feeding History:

Breast Fed: Y N How Long: _____ Formula Fed: Y N How Long: _____ Type: _____
Introduced to Solids at: _____ months Cow's milk at _____ months
Food/ Juice Allergies or Intolerances: Y N List: _____

Developmental History:

Delayed crawling: Yes No _____ Delayed Walking: Yes No _____
Sports Accident(s) Y N List: _____
Has Your Child Ever Been Involved in a Car Accident? Y N List: _____
Has Your Child Been Seen on am Emergency Basis? Y N List: _____
Other Accidents/Traumas/Falls Not Described Above? Y N List: _____

Pediatric Health Report

Listed below are common symptoms. If you have ever had a listed symptom in the past or present please check that symptom in the appropriate column.

Past		Present
[ ]	Bed Wetting	[ ]
[ ]	Convulsions	[ ]
[ ]	Dizziness/Fainting	[ ]
[ ]	Headaches	
[ ]	Muscular Incoordination	[ ]
[ ]	Hearing Loss	[ ]
[ ]	Ear Pain/Infection	[ ]
[ ]	Impaired Vision	[ ]
[ ]	Paralysis	[ ]

Past		Present
[ ]	Rapid Heart Beat	[ ]
[ ]	Slow Heart Beat	[ ]

Past		Present
[ ]	Poor Appetite	[ ]
[ ]	Abnormal Weight Gain	[ ]
[ ]	Abnormal Weight Loss	[ ]

Past		Present
[ ]	Asthma/Shortness of Breath	[ ]
[ ]	Chronic Cough/Flu	[ ]
[ ]	Sinus Infection/Drainage	[ ]
[ ]	Tonsillitis	[ ]

Past		Present
[ ]	Painful Urination	[ ]
[ ]	Frequent Urination	[ ]
[ ]	Blood in Urine	[ ]

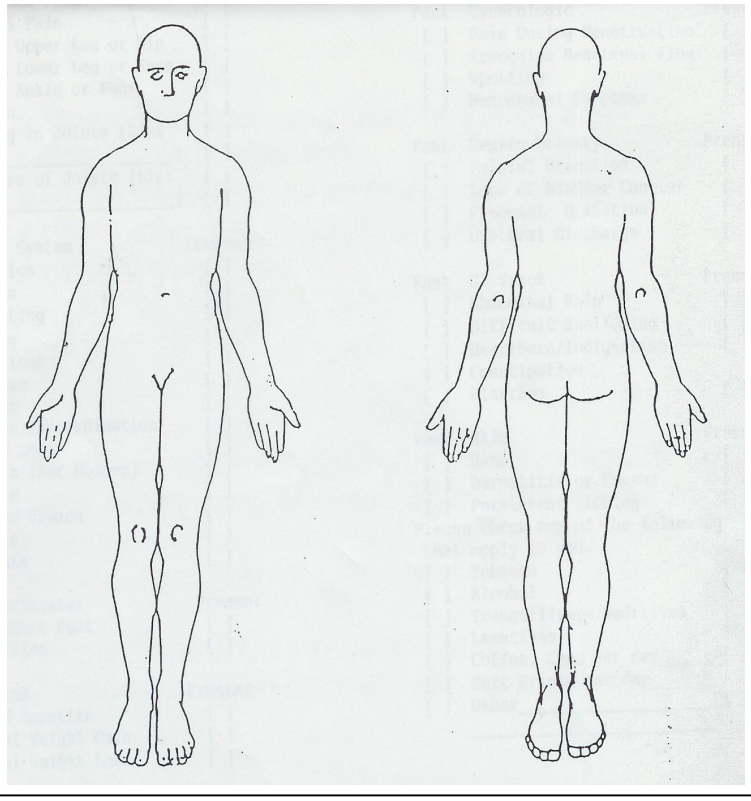
Past		Present
[ ]	Abdominal Pain	[ ]
[ ]	Heartburn/ Indigestion	[ ]
[ ]	Constipation	[ ]
[ ]	Diarrhea	[ ]

Past		Present
[ ]	Rash	[ ]
[ ]	Dermatitis or Eczema	[ ]
[ ]	Persistent Itching	[ ]
[ ]	Allergies	[ ]
[ ]	Scoliosis	[ ]
[ ]	Rheumatic Heart Disease	[ ]
[ ]	Diabetes	[ ]
[ ]	Colic	[ ]
[ ]	Kidney Infection	[ ]
[ ]	Cancer	[ ]
[ ]	Bladder Infection	[ ]

Past		Present
[ ]	HIV Positive/AIDS	[ ]
[ ]	"Growing Pains"	[ ]
[ ]	ADHD/ADD/Hyperactivity	[ ]
[ ]	Allergies	[ ]
[ ]	Recurring Fevers	[ ]
[ ]	Temper Tantrums	[ ]
[ ]	Seizures	[ ]
[ ]	Growing Pains	[ ]

Childhood Diseases

[ ]	Chicken pox	[ ]
[ ]	Rubella	[ ]
[ ]	Measles	[ ]
[ ]	Mumps	[ ]
[ ]	Whooping Cough	[ ]
[ ]	RSV	[ ]
[ ]	Croup	[ ]



PAIN DRAWING

If child experiencing pain, accurately mark the location and type of pain on the body to the left. Use the appropriate letter(s), to mark all affected areas.

Stabbing **(S)** Ache **(A)** Numbness **(N)**

Tingling **(T)** Burning **(B)**

Please mark on the line the **pain level (0-10)** that most accurately represents your pain:

Right Now _____

(Pain Scale)

(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (UNBEARABLE PAIN)

Authorization of Care of Minor: I hereby authorize this office and its' doctor(s) to administer care as they so deem necessary to my son/ daughter/ward (upon approval of parent or guardian).

Print Your Name _____

Signature _____ **Date:** ____ /____ /_____

Relationship to Patient: _____

Fetcho Family Chiropractic, L.L.C. •108 East Jefferson Street• Bloomfield, IA 52537 • (641) 664-2423

MINOR INFORMATION SHEET

Full Name: _____

FAMILY: *Please fill out parent's names or legal guardian if applicable.*

Mother's Name: _____

Father's Name: _____

Legal Guardian's Name: _____

Authorization of Care of Minor:
I hereby authorize Fetcho Family Chiropractic and its' doctor (s) to administer care as they deem necessary to my son/daughter/ward (upon approval of parent or guardian).

Date:_____/_____/_____

Mother's Signature: _____

Father's Signature: _____

Mother's Phone:_____Father's Phone: _____

Mother's Cell:_____Father's Cell: _____
