ORIGIN CHIROPRACTIC

PEDIATRIC CLIENT INTRODUCTION

CHILD'S NAME: _____

PARENT NAME: _____

ADDRESS | CITY | STATE | ZIP: _____

PHONE: _____ BIRTH DATE: _____ AGE: _____ SEX M/F: _____ NUMBER OF SIBLINGS: _____

CURRENT WEIGHT: _____ CURRENT HEIGHT: _____

PREGNANCY & FERTILITY HISTORY

Any fertility issues? ◯ Yes ◯ No If yes, Please explain: _____

Did mother smoke? ◯ Yes ◯ No

Did mother drink? ◯ Yes ◯ No

Did mother exercise? ◯ Yes ◯ No If yes, please explain: _____

Was mother ill while carrying? ◯ Yes ◯ No If yes, please explain: _____

Any Ultrasounds? ◯ Yes ◯ No If yes, please explain: _____

Please explain any notable episodes of mental or physical stress during pregnancy: _____

Please explain any other concerns or notable remarks about your child's conception or pregnancy: _____

LABOR & DELIVERY

Child's birth was: ◯ Vaginal Delivery ◯ Scheduled C-section ◯ Emergency C-section

At how many weeks was your child's birth? _____

Obstetrician/Midwife's name: _____

Please circle any applicable interventions or complications:

Breech Induction Pain Medications Epidural Episiotomy Vacuum Extraction Forceps Other: _____

Please describe any other concerns or notable remarks about your child's labor and/ or delivery: _____

Child's birth weight: _____ Child's birth height: _____ APGAR score: _____

GROWTH & DEVELOPMENT HISTORY

Is/was your child breastfed? ◯ Yes ◯ No If yes, how long? _____

Difficulty with breastfeeding? ◯ Yes ◯ No

Did they ever use formula? ◯ Yes ◯ No If yes, at what age? _____ If yes, what type? _____

Did/does your child ever suffer from colic, reflux, or constipation as an infant? ◯ Yes ◯ No If yes, please explain: _____

Please list your child's hospitalization and surgical history, including the year: _____

_____

Please list any major injuries, accidents, falls and/or fractures your child has sustained in his/her lifetime, including the year: _____

_____

Have you chosen to vaccinate your child? ◯ No ◯ Yes on an alternate schedule Yes, on schedule If yes, please list any vaccination reactions: _____

Has your child received any antibiotics or other prescription medication? ◯ Yes ◯ No If yes, how many times and list reason: _____

_____

Night terrors or difficulty sleeping? ◯ Yes ◯ No if yes, please explain: _____

_____

Behavioral, social or emotional issues? ◯ Yes ◯ No if yes, please explain: _____

_____

How many hours per day does your child typically spend watching a TV, computer, tablet or phone? _____

How would you describe your child's diet? Mostly whole, organic foods Pretty average High amount of processed foods

REASON FOR SEEKING CHIROPRACTIC CARE: _____

_____

_____

TOP 3 HEALTH GOALS: _____

AUTHORIZATION FOR CARE OF MINOR: I hereby authorize Origin Chiropractic and doctor(s) to administer care, as they so deem necessary to my on/daughter/ward (upon approval of parent or guardian)

SIGNED: _____ **DATE:** _____

How did you hear about us? _____

(For Doctor's Use)

Patient Name: _____ **Date of Birth:** _____ **Date of Exam:** _____

General Observations: _____

_____

_____

INFANTS: Accordion Check (noted resistance)L/R **Grimacing?** L/R **Glute Squeeze** L/R **Palpatory Tension Level** _____

_____

Leg Lengths: L short/ R short in extension L short/ R short in flexion

Primitive Reflexes: Rooting (0-4 mo) Palmar Gallant (0-2) Babinski

Additional Notes: _____

_____

_____