pediatric health information

stay tuned chiropractic

THIS FORM IS FOR CHILDREN 10 YEARS OF AGE OR YOUNGER

Child's Name: First _____ Last _____ M.I. ____

Nickname_____ Birth Date ____/____/_____ Age _____ Gender ❑ M ❑ F

Mother's Name_____ Father's Name_____

Address _____ City _____ Zip _____ Date ___/___/____

Parent Phone: Home _____ Mobile _____ Work _____

Parent Email _____Child's School _____

Siblings_____ Ages _____

Emergency Contact Person _____ Contact Number _____

Pediatrician Name _____ Phone # _____

Last visit to MD ____/___/____ Why? _____

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

Reason for today's visit? _____

Type of Birth: (circle one) Normal/Vaginal Forceps Breech Home Hospital Cesarean

APGAR *(American Pediatric Gross Assessment Record)* Scores if known: _____

Problems during pregnancy? _____

Problems with labor/delivery? _____

Child's Birth Weight ____ Current Weight ____ Present at birth? Jaundice (yellow) ❑ Cyanosis (blue) ❑

Congenital Anomalies/Birth Defects _____

Infant feeding: Breast ❑ Bottle ❑ Formula ❑ Quality of sleep: Good ❑ Fair ❑ Poor ❑

Childhood Diseases _____

Immunization History _____

Developmental History – At what age did your child:

Smile _____ Hold head up _____ Follow object with his/her eyes _____Crawl _____ Sit alone _____

Hold object with hands _____ Stand _____ Walk _____ Talk _____

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

Anemia ❑ Blood disorder ❑ Diabetes ❑ Headaches ❑ Rheumatic fever ❑

Allergies ❑ Broken bones ❑ Diarrhea ❑ Heart trouble ❑ Seizures ❑

Asthma ❑ Chronic ear infections ❑ Digestive disorders ❑ Hyperactivity ❑ Stomachaches ❑

Backaches ❑ Colds/flu ❑ Dizziness ❑ Hypoglycemia ❑ Ruptures/hernias ❑

Bed Wetting ❑ Constipation ❑ Fainting ❑ Joint problems ❑ Walking problems ❑

Behavorial problems ❑ "Growing pains" ❑ Paralysis ❑ Other _____

Surgery? _____ Accidents? _____

Medication/s? _____ Resaon/s _____

Family history of diseases _____

Has your child ever been treated on an emergency basis? Y ❑ N ❑

If so, why? _____

I _____hereby certify that the information given on this form is accurate to the best of my knowledge and recollection. I agree to allow Dr. Michelle Fox and her designated assistants to perform diagnostic assessments on my child in order to achieve the most thorough evaluation of his/her health as possible, and to determine if he/she is a candidate for chiropractic care at this time. I have read the Privacy Policy of Stay Tuned Chiropractic, or I am aware that it is available for my viewing.

Parent/Guardian Signature_____ Date ____/____/_____