SEAHURST

Chiropractic and Wellness Clinic

PEDIATRIC INFORMATION FORM (BIRTH-12 YRS)

Patient Information

Name:_____Date: _____
Date of birth:_____Age:_____Sex: ☐ Male ☐ Female
Parent/Guardian's name(s): _____
Street address: _____
City:_____State:_____Zip code: _____
Home phone:_____Cell phone: _____
Email address: _____
Insurance Provider/ID#: _____
Whom may we thank for referring you? _____

Prenatal History

Any complications during pregnancy: _____
Any alcohol? Yes/No Any tobacco? Yes/No Any vaccines/medication? Yes/No
Reason for vaccines/medication: _____
Illness/infections during pregnancy: _____
Ultrasounds or other testing: _____
What things were done to stay healthy during pregnancy?

_____

_____

Birth History

Place of birth: ☐ Home ☐ Birthing Center ☐ Hospital
Provider: ☐ Midwife ☐ **OB-Gyn** ☐ Other
Type of birth: ☐ Vaginal ☐ Cesarean
Were pain medications used? Yes/No Pitocin used? Yes/No
Was labor induced? Yes/No If yes, why? _____
Birth trauma? ☐ Doctor assisted ☐ Twisting/Pulling ☐ Vacuum Extraction ☐ Forceps
APGAR score if known: _____
Did your child have a misshaped skull/head? Yes/No
Did you breast---feed your child? Yes/No How long? _____
Any food allergies: _____
Has your child been immunized? Yes/No
Reason: ☐ Informed decision ☐ Recommended ☐ Didn't know I had a choice
Did your child have any negative reaction to the vaccines? Yes/No
If yes, were they reported? Yes/No
Has your child ever had any surgeries? Yes/No
If yes, elaborate: _____
Has your child been on antibiotics? Yes/No

(See Reverse)

If yes, how often and what purpose? _____
Is your child currently taking any medication? Yes/No
If yes, how often and what purpose? _____
Is your child currently taking any vitamins? Yes/No

Baby/Toddler (0---4)

Have any of the following occurred?

Jaundice	Colic	Reflux
Anemia	Frequent diarrhea	Fall from a changing table
Cyanosis	Constipation Sleeping	Fall out of crib
Seizures	problems Frequent	Fall off playground
Infections	fevers Frequent crying	Tumble down stairs
Tonsillitis	spells Repeated colds	Play in a Johnny Jumper
Frequent ear infections		Car accident

Other _____

Child (5---12)

Have any of the following occurred?

Fall from a tree	Stomach pains	Bed---wetting
Fall off a bicycle	Hyperactivity/Autism	Asthma
Fall on playground	Leg/Knee pains	Allergies
Sports accident	Scoliosis	Growing Pains
Car accident	Learning difficulties	Headaches/Migraines

Other _____

Which of the above bothers your child the most? _____
When did it begin?_____Is it getting worse? Yes/No
Does it affect activity? ☐ Not at all ☐ Somewhat ☐ Always
Does your child participate in any athletic extra curricular activities? Yes/No
If yes, which ones? _____
Rate your child's diet: ☐ Well---balanced ☐ Average ☐ High sugar/processed foods
Does your child consume artificial sweeteners? Yes/No
Fluoridated water? Yes/No
Number of hours your child sleeps?_hours/day Sleep quality? ☐ Good ☐ Fair ☐ Poor

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Authorization to treat a Minor

I,_____the undersigning parent/guardian having legal custody/guardianship of_____, a minor, do herby authorize, request, and direct the staff and doctors of Seahurst Chiropractic to perform in judgment any examination and chiropractic diagnosis or treatment which is deemed necessary.

Patient's name: _____
Parent/Guardian's signature:_____Date: _____