

Pediatric Patient History

Name _____ Date _____ Social Sec. # _____
Address _____ City _____ State _____ Zip _____
H.Phone _____ W.Phone _____ C.Phone _____
Date of Birth _____ Age _____ Parents Occupation _____ Employer _____
Has the child ever received Chiropractic Care? _____ How were you referred to our office? _____
Who is the child's primary/family doctor? _____
What is the child's reason for today's visit? _____

Labor and Delivery

-How long was the labor from the first regular contractions to the birth? _____ Hours
-How long was the 2nd stage (the pushing phase) of the labor? _____ Hours

- Yes No
- () () Hospital birth? _____
 - () () Home birth? _____
 - () () Midwife assisted? _____
 - () () Vaginal delivery? _____
 - () () Planned C-section? _____
 - () () Emergency C-section? _____
 - () () Was birth induced (pitocin)? _____
 - () () Forceps delivery? _____
 - () () Vacuum extraction? _____
 - () () Anesthesia administered? _____
 - () () Fetal distress? _____
 - () () Meconium staining? _____
 - () () Head presentation? _____
 - () () Face presentation? _____
 - () () Breech presentation? _____

Baby's Condition Immediately After Birth:

-Apgar Scores at 1 minute _____ / 10 at 5 minutes _____ / 10
-Baby's Crying baby cried immediately after birth _____
cried strongly _____ weak cry _____ did not cry for _____ minutes
-Baby's Color pink all over _____ blue face _____ blue hands / feet _____
-Baby's Activity arms and legs actively moving _____ floppy baby _____
-Intensive Care was required _____ days in Neonatal Intensive Care Unit _____
-Medication given at birth _____ Vaccines administered _____
-Birth weight _____ lbs / kgs Birth length _____ ins / cms Baby home on _____

Growth and Development

- () () Was the child taught how to care for their spine?
- () () Was the child breastfed?
- () () Childhood illnesses?
- () () Accidents?
- () () Did they fall while learning how to walk?
- () () Did they have other traumas? What? When?

Consent to Treat a Minor Child

I hereby authorize Dr. Christy M. Agren and the staff of Chiropractic Life Center to administer chiropractic care as deemed necessary to _____ (child's name)

Guardians Signature Authorizing Care _____ Date _____