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"Life is better when you are WELLadjusted"

PEDIATRIC PATIENT INFORMATION

Welcome to our clinic. Please take a moment to fill out this entire form and please ask if you have any questions. Thank you for choosing us for your health care needs. We look forward to being of service to you!

PATIENT INFORMATION:

Child's Name: _____ Child's Nickname: _____
Sex: M / F Date of Birth: _____ Age: _____ Home Phone: (____) _____
Home Address: _____ City: _____ State: _____ Zip: _____
How did you hear about our office? _____
Current Height: _____ Current Weight: _____ Purpose of this appointment: _____

INFORMATION:

Father's Name: _____ Mother's Name: _____
Father's Cell Phone: _____ Mother's Cell Phone: _____
Father's Work # _____ Mother's Work # : _____
Parent's Marital Status: Single Married Divorced Widowed
Email: _____ List Ages of Other Children in Family: _____

OFFICE POLICY:

Welcome to our office! Our goal is to serve your family with exceptionally friendly and prompt service, and provide the best family health care available. The office is a place of healing. In consideration of other patients all cell phones must be turned off during your time in our office.

AUTHORIZATION OF USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION:

I hereby voluntarily authorize WELLadjusted: a chiropractic wellness center to release any and all medical information, until this authorization is further revoked, to:

_____ Relationship: _____
_____ Pediatrician/ Family MD

I understand that if the person or organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. The below named patient representative acknowledges they have received a copy of Notice of Privacy Practices.

Signature of Patient Representative: _____

Relationship: _____ Date: _____

You have the right to revoke this authorization at any time, provided that you do so in writing and except to the extent that we have already used or disclosed the information in reliance on this authorization.

AUTHORIZATION TO TREAT A MINOR:

I hereby request and authorize the doctor(s) at WELLadjusted: a chiropractic wellness center to perform any necessary diagnostic tests and render chiropractic adjustments and other needed treatments. As of this date, I have the legal right to select and authorize health care services for the minor child named above. (If applicable)

Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

Name (please print)

Signature

Date

PREGNANCY HISTORY

What was the term of your pregnancy? _____ weeks Total maternal weight gain: _____ lbs.

Maternal Nutrition and Exercise: _____

Any problems during pregnancy? _____

CHECK WHICH OF THE FOLLOWING YOU EXPERIENCED DURING PREGNANCY and EXPLAIN:

- Abnormal Bleeding _____
- Motor Vehicle Accidents _____
- High Blood Pressure _____
- Diabetes _____
- Anemia _____
- Falls _____
- Swollen Ankles _____
- Morning Sickness _____
- Indigestion _____
- Thyroid Problems _____
- Seizures _____
- Heart Problems _____
- Back Pain _____
- Hospitalizations _____
- Other _____

SOCIAL HISTORY WHILE PREGNANT: (circle all that apply)

Do you: Exercise regularly Eat a balanced diet Obtain sufficient rest

Do you smoke- (packs/day): No Less than 1 1-2 2-3 3-4 More than 5

Do you Drink Coffee/Tea- (cups/day): No Less than 1 1-2 2-3 3-4 More than 5

Do you Drink Alcohol- (drinks/day) : No Less than 1 1-2 2-3 3-4 More than 5

MEDICATIONS WHILE PREGNANT:

List all including home remedies, prescription meds, non-prescribed drugs, and over-the-counter meds.

- _____ _____
- _____ _____
- _____ _____
- _____ _____

LABOR AND DELIVERY HISTORY

Were there any problems during labor and delivery? _____

Third Trimester Presentation (circle): Vertex Breech Transverse Face/Brow

What was the location of the birth (circle): Home Birthing Center Hospital

Type of Birth (circle): Normal Vaginal Forceps Planned Cesarean Suction/Vacuum Emergency Cesarean

Any Obstetrical Interventions? _____

BABY'S CONDITION AT BIRTH:

APGAR Scores: _____

Was there presence of any of the following? (check which apply)

- Jaundice (Yellow)
- Cyanosis (Blue)
- Congenital Anomalies

How was the baby's crying at birth? (check which apply)

- Cried immediately after birth
- Did not cry for _____ minutes
- Cried strongly
- Weak cry

Birth Weight _____ lbs Birth Length _____ inches

Was intensive care required? _____

Were there any medications given to baby at birth? _____

Were there any vaccines given to baby at birth? _____

NEWBORN CASE HISTORY

Pediatrician/ Family MD: _____

Date of last visit: _____ Purpose: _____

INFANT FEEDING:

Breast Fed: Yes / No

Does the baby prefer feeding on one side than the other? Yes / No Side preferred: Left / Right

Bottle Fed: Yes / No Which formula? _____

After a feeding does the baby frequently spit-up? _____

SLEEPING:

Number of hours sleeping per night: _____ How is the quality of sleep? (circle): Great Fair Poor

Does the baby have a preferred sleeping position? Yes/No. If yes, please explain: _____

CHECK WHICH OF THE FOLLOWING YOUR BABY EXPERIENCES or EXPERIENCED and EXPLAIN:

- Pass a lot of intestinal gas _____
- Frequently arches head and neck backwards _____
- Cries or becomes irritable during diaper change _____
- Experience any type of fall _____
- Been in an automobile accident _____
- Suffered from a fever _____
- Suffered from an ear infection _____
- Colic _____
- Indigestion _____
- Experience any other trauma _____
- Seizures _____
- Heart Problems _____
- Been Vaccinated _____
- Hospitalizations _____
- Other _____

ACCOMPLISHMENTS DEVELOPMENTALLY:

(PLEASE CHECK WHICH SKILLS YOUR CHILD CAN PERFORM IN EACH SECTION)

Gross Motor Skills

- holds head up from the table momentarily
- pushes up with hands and forearms
- infant can be pulled up into a sitting position by the hands
- sits unsupported in the upright position
- rolls from back to stomach
- crawls
- stands holding onto something
- walks with someone holding onto one hand
- walks unassisted
- runs
- negotiates stairs placing 2 feet on each step
- negotiates stairs placing 1 foot on each step
- hops on one foot

Social Skills

- smiles
- reaches for familiar objects
- plays with hands
- plays with feet
- clearly shows joy and pleasure
- feeds self with fingers
- plays peek-a-boo
- understands yes and no

Fine Motor Skills

- primitive grasp reflex present
- holds and shakes a rattle placed in the hand
- grabs objects by him/her self
- moves an object from one hand to the other
- self-feeding, can hold and eat a cookie
- checks objects by placing them in the mouth
- picks up object with thumb and pointer finger
- turns 2 to 3 pages of a book at a time
- turns pages of a book 1 at a time
- builds a tower containing at least 5 blocks
- builds a tower containing at least 10 blocks

Communication Skills

- makes cooing sounds
- laughs
- uses one syllable words such as ma
- uses two syllable words such as mama
- uses 2 to 3 word sentences

Adaptive Skills

- drinks from a cup unassisted
- holds own bottle
- feeds self with spoon or fork
- able to identify and match some colors
- copies a circle
- copies a cross