PEDIATRIC PATIENT INTRODUCTION

Child's Name: :_____Mother's Name: _____

Father's Name: _____

Sex: □Male □ Female

Date of Birth: _____Age: _____Birth Weight: _____Current Weight: _____

Home Address: _____

City: _____ Province: _____ Postal Code: _____

Phone Number: Home: _____ Work: _____ Cell: _____

Email Address: _____

Alberta Health Care Number: _____

Type of Birth: Normal Vaginal ____ Forceps ____ Breech ____ Cesarean ____

Place of Birth: Home____ Birthing Center _____ Hospital _____

Apgar Scores _____ Was there a presence at birth of: _____ Jaundice (yellowness)
_____Cyanosis (blue)

Congenital Anomalies/defects: _____

Infant Feeding: Breast _____ Bottle _____ Formula _____

Number of hours of sleep per night: _____ Quality of sleep: _____

Obstetrician/Midwife: Name: _____ Location: _____

Pediatrician/Family Doctor: _____

Date of last visit to Doctor: _____ Purpose:_____

Has your child ever been treated on an emergency basis? Describe:

_____

Authorization for care of a minor

I hereby authorize this clinic and it's doctor(s) to administer care as they so deem necessary to my son/daughter/ward (upon approval of parent or guardian)

Date: _____

Signature: _____ **Witnessed:** _____

PEDIATRIC CASE HISTORY

Pregnancy History:

Delivery/Birth History:

Developmental History: At what age did the child:

Hold up Head _____ Sit alone _____ Crawl _____ Stand _____

Childhood Diseases: Chicken pox _____ Mumps _____ Measles _____ Rubella _____

Rubeola _____ Whooping Cough _____

Has this child ever suffered from: (please circle)

Dizziness	Backaches	Heart Trouble	Chronic Earaches
Diabetes	Tuberculosis	Hypertension	Colds/Flu
Arthritis	Headaches	Asthma	Allergies
Neuritis	Digestive Disorders	Sinus Trouble	Constipation
Anemia	Rheumatic Fever	Orthopedic Problems	Diarrhea
Poor Appetite	Hyperactivity	Sugar Concentration	Behavioral Problems
Bed Wetting	Convulsions	Paralysis	Muscle Jerking
Fainting	Walking Problems	Broken Bones	Ruptures/Hernias
Neck Problems	Arm Problems	Leg Problems	Growing Pains
Joint Problems	Blood Disorders	Stomach Aches	Other

Present History:

Surgery: _____

Medications: _____

Accidents: _____

Family History: _____

History of Birth

Hospital / Birthing Center: □ Home □ Medical □ Midwife Duration of Gestation: _____ weeks

Was the birth assisted? □ Yes □ No If yes, how? □ Forceps □ Vacuum Extraction □ C-Section □ Induced Labour

Were medications given to the mother at birth? □ Yes □ No If yes, what? _____ Duration of Birth: _____

Was the delivery normal? □ No □Yes If no, what complications were there at birth? _____

APGAR at Birth _____ APGAR after 5 minutes _____ Birth Weight _____ Birth Length _____

Growth and Development

Was the infant alert & responsive within 12 hours of the delivery? □ Yes □ No If no, explain: _____

At what age did the child: Respond to sound? _____ Follow an object? _____ Hold up head? _____ Vocalize? _____

Sit alone? _____ Teethe? _____ Crawl? _____ Walk? ____ Do his/her sleeping patterns seem normal? □ Yes □ No

Describe any health problems that exist on the mother's side of the family? (e.g. Cancer, Diabetes etc.) _____

_____

The father's side? _____

Do the child's siblings have any health problems? □ Yes □ No If yes, describe: _____

The following information is very important because many of the problems that chiropractors work with are caused by stressors.

Chemical Stressors

During pregnancy, did the mother: 1. Smoke □ Yes □ No 2. Drink alcohol? □ Yes □ No 3. Take supplements/vitamins? □ Yes □ No

4. Take drugs? □ Yes □ No If yes, what? _____ 5. Become ill? If so, how? _____

5. Receive ultrasounds? □ Yes □ No If yes, how many?_____ 6. Receive invasive procedures (ie. amniocentesis, CVS)? □ Yes □ No

Was your child breast fed? □ Yes □ No If yes, for how long? _____ weeks months years

At what age was: 1a. Formula introduced? _____ b. Brand? _____ 2. Cow's milk? _____ yrs 3. Solid foods? _____ yrs

Did your child receive vaccinations? □Yes □ No If yes, which ones? _____ Did your child react to them? □Yes □ No

Has your child had antibiotics? □ Yes □ No If yes, how many courses has the child had so far & why? _____

Any pets at home? □ Yes □ No Any smokers at home? □ Yes □ No If yes, how much? _____

Psychological Stressors

Any difficulties with lactation? □ Yes □ No Any problems bonding? □ Yes □ No Does your child seem normal to you? □ Yes □ No

Does the child have any behaviour _____

problems? □ Yes □ No If yes, what? _____

Does your child have difficulties sleeping (e.g. night terrors, sleepwalking, etc.)? □ Yes □ No If yes, specify: _____

Did your child go to daycare? □ Yes □ No From what age? _____ yrs Average no. of hours of TV/Computer per week? _____ hrs

Traumatic Stressors

Any evidence of trauma during birth? □ Bruises □ Odd shaped head □ Stuck in birth canal □ Fast and/or excessively long birth

□ Respiratory Depression □ Cord around neck □ Other _____

Any falls/accidents during pregnancy? □ Yes □ No Has the child had any major falls since birth? □ Yes □ No If yes, did the child need stitches or cause a fracture? Please describe: _____

Any hospitalizations? □ Yes □ No Please explain: _____

Does your child play sports? □ Yes □ No Number of hours per week? _____ Age child began _____ yrs

Weight of school backpack? _____lbs Approx. Hours spent at play per week? _____ hrs