collins chiropractic
You were born to be healthy.

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: _____
Email address: _____
Home phone: _____ Cell phone: _____
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 vaccinated? 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:

_____

(See Reverse)

Has your child been on antibiotics? Yes/No
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	Fall out of crib
Seizures	Sleeping problems	Fall off playground
Infections	Frequent fevers	Tumble down stairs
Tonsillitis	Frequent crying spells	Play in a Johnny Jumper
Frequent ear infections	Repeated colds	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
Number of hours your child sleeps? _____ hours/day
Sleep quality? ☐ Good ☐ Fair ☐ Poor
Is there anything else the Doctor should know?

_____

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 Collins Chiropractic to perform in judgment any examination and chiropractic diagnosis or treatment which is deemed necessary.

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