collins chiropractic
You were born to be healthy.

PEDIATRIC INFORMATION FORM (13-17 YRS)

Patient Information

Name: _____Date: _____
Date of birth: _____ Age:____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?
_____

Patient History

How would you describe the pregnancy? ☐ Normal ☐ Somewhat difficult ☐ Very difficult
How would you describe infancy? ☐ Normal ☐ Somewhat difficult ☐ Very difficult
How would you describe childhood? ☐ Normal ☐ Somewhat difficult ☐ Very difficult
If you answered anything but normal, why? _____
_____
_____
How would you describe overall physical development?
☐ Above average ☐ Typical ☐ Behind schedule
How would you describe overall mental development?
☐ Above average ☐ Typical ☐ Behind schedule
Any childhood illnesses/diseases?
_____
Any surgeries?
_____
Any accidents?
_____
Has your child been vaccinated? Yes/No
If yes, which ones?_____
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 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
If yes, how often and what purpose?
_____
Is there anything significant in patient's health history the Doctor should know?
_____ *(See Reverse)*

Health & Wellness

What is the reason for your visit today? ☐ Wellness Check-Up ☐ Other
Other:

_____

If other, how long has this been a concern?

_____

Is it getting worse? ☐ Yes ☐ No ☐ Not sure

Does it affect activity? ☐ Not at all ☐ Somewhat ☐ Always

Has anything been done already to address this concern?

_____

Are any of the following symptoms present?

Stomach pains	Allergies	Repeated colds
Hyperactivity/Autism	Growing Pains	Digestion
Leg/Knee pains	Headaches/Migraines	General fatigue
Scoliosis	Seizures	Acne/Skin problems
Learning difficulties	Infections	Depression
Low energy	Tonsillitis	Menstrual cramps
Asthma	Diarrhea	Anxiety
Irritability/Moodiness	Constipation	Excessive hunger
Low self-esteem	Sleeping problems	

Other_____

Do you participate in any athletic extra curricular activities? Yes/No

If yes, which ones? _____

Rate your diet: ☐ Well-balanced ☐ Average ☐ High sugar/processed foods

Do you consume artificial sweeteners? Yes/No

Rate your exercise: ☐ Frequently ☐ Sometimes ☐ Never

How many glasses of water do you drink? _____/day

Number of hours you sleep? _____ hours/day

Sleep quality? ☐ Good ☐ Fair ☐ Poor

Rate your general mood: ☐ Happy ☐ Melancholy ☐ Depends on the day

Is there anything else you would like the Doctor to 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: _____