PEDIATRIC REGISTRATION AND HISTORY

PATIENT INFORMATION

Child's Name:_____Date of Birth:_____

Parents'/Guardians' Names:_____

Home Address: _____

Home Phone:_____ Cell:_____

Siblings Names & Ages:_____

How did you hear about our office?_____

Has your child ever been treated by a Chiropractor? ☐ No ☐ Yes How long ago?_____

Clinic/Doctor Name:_____ Reason for change:_____

PRENATAL HISTORY

Complications During Pregnancy: ☐ No ☐ Yes (Brief Description):_____

Medications during pregnancy: ☐ No ☐ Yes (Brief Description):_____

Exposure to drugs, alcohol, cigarettes, or second hand smoke? ☐ No ☐ Yes (Brief Description):_____

BIRTH EXPERIENCE

Location of Birth: ☐ Home ☐ Hospital ☐ Birthing Center ☐ Other:_____

Medications during labor/delivery (including IV antibiotics/epidural): ☐ No ☐ Yes (Brief Description):_____

Was the delivery: ☐ Vaginal ☐ C-Section Were any interventions used?: ☐ Forceps ☐ Vacuum ☐ Other

POSTNATAL/INFANT HISTORY

How many weeks gestation was the baby at birth? _____ Weight:_____ Length:_____

APGAR scores (if known) at: 1 minute:_____/10 5 minutes:_____/10 NICU necessary? ☐ No ☐ Yes

Medications given at time of birth? ☐ No ☐ Yes (Brief Description):_____

Was your child: ☐ Breastfed? ☐ Formula fed? ☐ Both? For how long?_____

Does your child prefer one breast over the other? ☐ No ☐ Yes (If yes: Which side?)_____

HEALTH CONCERNS

☐ Asthma
☐ Respiratory Tract Infections
☐ Sinus Problems
☐ Ear Infections
☐ Tonsillitis/Strep Throat
☐ Frequent Colds/Croup
☐ Recurrent Fevers

☐ Eczema
☐ Rashes
☐ Allergies
☐ Food Sensitivities
☐ Digestive Problems
☐ Frequent Diarrhea
☐ Constipation

☐ Flatulence
☐ Headaches/Migraines
☐ Neck Pain
☐ Torticollis/Head Tilt
☐ Trouble Feeding on One Side
☐ Sleep Problems
☐ Night Terrors

☐ Tip Toe Walking
☐ Sensory Processing Issues
☐ Seizures
☐ Tremors/Shaking
☐ ADD/ADHD
☐ Autism/PPD
☐ Other:_____

_____

Has your child ever fallen from any high places? ☐ No ☐ Yes:_____

Has your child ever been involved in a motor vehicle accident? ☐ No ☐ Yes:_____

Has your child ever been seen for an emergency? ☐ No ☐ Yes:_____

Has your child broken any bones? ☐ No ☐ Yes:_____

Has your child had any previous hospitalizations? ☐ No ☐ Yes:_____

Has your child had any previous surgeries? ☐ No ☐ Yes:_____

Does your child use a tablet, computer, or video game? ☐ Never ☐ Rarely ☐ Daily ☐ Several hours/day

Does your child watch TV? ☐ Never ☐ Rarely ☐ Daily ☐ Several hours/day

Does your child exercise? ☐ Never ☐ Daily ☐ Weekly Does your child play contact sports? ☐ Yes ☐ No

Does your child sleep on their: ☐ Back ☐ Side ☐ Belly

Does your child carry a backpack? ☐ No ☐ Yes Does it weigh less than 15% of their body weight? ☐ No ☐ Yes

Does your child wear custom orthotics? ☐ No ☐ Yes (For what purpose?):_____

CHEMICAL STRESSORS

Has your child been vaccinated? ☐ No ☐ Yes (personal research) ☐ Yes (MD recommendation)
Which vaccines?:_____

Did your child have any negative reactions to the vaccinations? ☐ No ☐ Yes:_____

Does your child receive annual flu shot? ☐ No ☐ Yes

Has your child been prescribed antibiotics? ☐ No ☐ Yes (how often and what for):_____

Has your child been exposed to OTC medications? ☐ No ☐ Yes (how often and which ones?):_____

_____

How many daily glasses of: Water:_____ Juice: _____ Milk: _____ Soda: _____

Does your child eat gluten? ☐ No ☐ Yes Does your child eat dairy? ☐ No ☐ Yes
What age did you introduce solid foods to your child? _____ months

Any food/drink allergies or sensitivities: ☐ No ☐ Yes:_____

Does your child take a probiotic daily? ☐ No ☐ Yes (CFU's/day):_____

Does your child take Omega 3 Fish Oils daily? ☐ No ☐ Yes (IU's/day):_____

Other supplements/homeopathics? ☐ No ☐ Yes _____
Do you feel your child is developmentally appropriate for their age?

Intellectually: ☐ No ☐ Yes Emotionally: ☐ No ☐ Yes Physically: ☐ No ☐ Yes

INSURANCE / CONSENT FOR CARE

I certify that I, and/or my dependent(s) have insurance coverage with (name of insurance company)_____ and assign directly to Damato Chiropractic Center and/or associates of this practice all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named doctor and/or practice may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

I, _____, being the parent or legal guardian of_____
hereby grant my permission for my child to receive chiropractic care.

Parent/Guardian Signature:_____ Date:_____

Print Name:_____ Relationship to Patient:_____