PEDIATRIC PATIENT INTRODUCTION

Child's Name:_____ Mother's Name:_____ DOB:_____

Case Number:_____ Father's Name:_____ DOB:_____

Address:_____ City/Town:_____ State:_____ Zip:_____

Home Phone:_____ Mother's Work Phone:_____ Mother's Cell Phone:_____

Email:_____ Father's Work Phone:_____ Father's Cell Phone:_____

Birth Date:_____ _____ _____ Age:_____ Sex:_____ Number of Siblings:_____ Referred by:_____

Birth Weight:_____ Birth Length:_____ Current Weight:_____ Current Length:_____

Third Trimester Presentation: Vertex_____ Breech_____ Transverse_____ Face/Brow_____

Type of Birth: Normal Vaginal_____ Forceps_____ Cesarean_____ Suction Cap or Vacuum_____

Location: Home_____ Birthing Center_____ Hospital_____

Problems During Pregnancy:_____

Problems During Labor/Delivery:_____

Apgar Scores:_____ _____ Was there presence at birth of: Jaundice (Yellow)? _____ Cyanosis (Blue)? _____

Congenital Anomalies/Defects?_____ If Yes, Please Explain?_____

Infant Feeding: Breast_____ Bottle_____ If Bottle, Which Formula? _____

Number of Hours Sleeping per Night:_____ Quality of Sleep: Good_____ Fair_____ Poor _____

Obstetrician/Midwife:_____

Pediatrician/Family MD:_____

Date of Last Visit:_____ _____ _____ Purpose:_____

Immunization History:_____

Number of doses of antibiotics your child has taken: During the past six months_____ During his/her lifetime_____

Previous Chiropractor:_____

Date of Last Visit:_____ _____ _____ Purpose:_____

Has your child ever been treated on an emergency basis?_____ If yes, please explain:_____

Purpose of this Appointment:_____

Insurance/Billing Information:_____ Policy #:_____

AUTHORIZATION FOR CARE OF MINOR

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

SIGNED:_____ WITNESSED:_____ DATE_____ _____ _____

I realize that I am responsible for all fees charged by this office and I agree to pay for all services provided. X-rays remain the property of this office.

SIGNED:_____ DATE_____ _____ _____

PEDIATRIC CASE HISTORY

Delivery/Birth History:_____

_____

_____

_____

At what age did the child:

Respond to Sound_____ Follow an Object with His/Her Eyes_____ Hold Head Up _____

Sit Alone_____ Crawl_____ Stand_____ Walk Alone_____

At what age, if ever, did this child suffer from the following childhood diseases?

Chickenpox_____ Mumps_____ Measles_____ Rubella_____

Rubeola_____ Whooping Cough_____ Other_____

Has this child ever suffered from:

- ☐ Headaches
- ☐ Dizziness
- ☐ Fainting
- ☐ Seizures/Convulsions
- ☐ Heart Trouble
- ☐ Chronic Earaches
- ☐ Sinus Trouble
- ☐ Asthma
- ☐ Colds/Flu
- ☐ Colic
- ☐ Orthopedic Problems
- ☐ Neck Problems
- ☐ Arm Problems
- ☐ Leg Problems
- ☐ Joint Problems
- ☐ Backaches
- ☐ Poor Posture
- ☐ Scoliosis
- ☐ Walking Trouble
- ☐ Broken Bones
- ☐ Digestive Disorders
- ☐ Poor Appetite
- ☐ Stomach Aches
- ☐ Reflux
- ☐ Constipation
- ☐ Diarrhea
- ☐ Diabetes
- ☐ Hypertension
- ☐ Anemia
- ☐ Bed Wetting
- ☐ Behavioral Problems
- ☐ ADD/ADHD
- ☐ Ruptures/Hernia
- ☐ Muscle Pain
- ☐ Growing Pains
- ☐ Allergies to_____
- ☐ Allergies to_____
- ☐ Allergies to_____
- ☐ Other_____
- ☐ Other_____

Has this child ever suffered the following spinal traumas?

- ☐ Fall in baby walker
- ☐ Fall from crib
- ☐ Fall from highchair
- ☐ Fall from changing table
- ☐ Fall from bed or couch
- ☐ Fall off swing
- ☐ Fall off slide
- ☐ Fall off monkey bars
- ☐ Fall off skateboard or skates
- ☐ Fall off bicycle
- ☐ Fall down stairs
- ☐ Other_____

Has this child ever sustained an injury playing organized sports?_____ If yes, please explain:_____

_____

Has this child ever sustained injuries in an auto accident?_____ If yes, please explain:_____

_____

Present History:_____

_____

_____

_____

Surgery:_____

Medications:_____

Accidents:_____

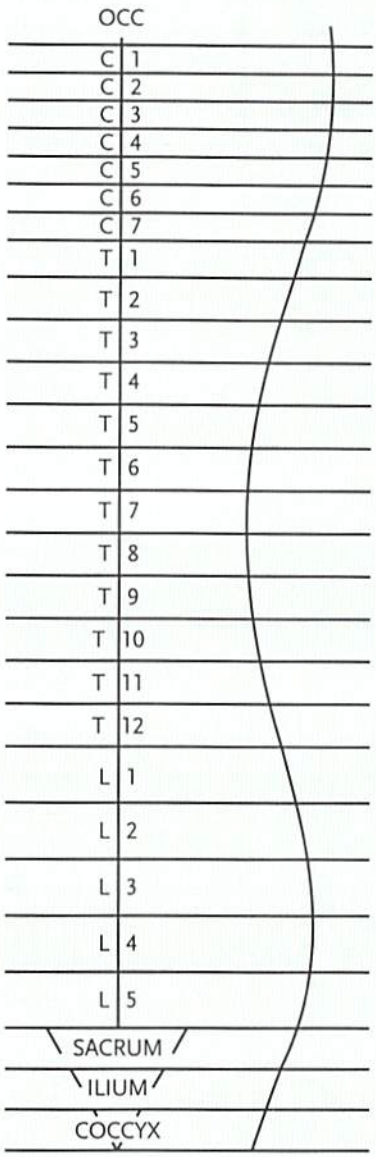
Family History:_____

PEDIATRIC CHIROPRACTIC EXAMINATION

Case Number_____ Dr._____ Date_____

Name_____ Age_____ HT_____ WT_____ L/R Hand

X-RAY LISTINGS



SPINAL PALPATION

Cervicals			
C1	L	R	B
C2	L	R	B
C3	L	R	B
C4	L	R	B
C5	L	R	B
C6	L	R	B
C7	L	R	B
Thoracics			
T1	L	R	B
T2	L	R	B
T3	L	R	B
T4	L	R	B
T5	L	R	B
T6	L	R	B
T7	L	R	B
T8	L	R	B
T9	L	R	B
T10	L	R	B
T11	L	R	B
T12	L	R	B
Lumbars			
L1	L	R	B
L2	L	R	B
L3	L	R	B
L4	L	R	B
L5	L	R	B
Sacrum/Ilium			
S.I. Joint	L	R	B
PI	L	R	
AS	L	R	
EX	L	R	
IN	L	R	

CERVICAL MOTION STUDIES

	Norm	Exam Findings
Flexion	60	
Extension	50	
L. Rotation	80	
R. Rotation	80	
L. Lat. Flex.	40	
R. Lat. Flex.	40	

DORSO-LUMBAR MOTION STUDIES

	Norm	Exam Findings
Flexion	90	
Extension	30	
L. Rotation	30	
R. Rotation	30	
L. Lat. Flex.	20	
R. Lat. Flex.	20	

DORSO-LUMBAR MOTION STUDIES

Head Tilt_____

Head Rot._____

Shld. High_____

Scapula High_____

Post. Scapula_____

Ilia High_____

Scoliosis_____

Kyphosis_____

Lordosis_____

LEG CHECK

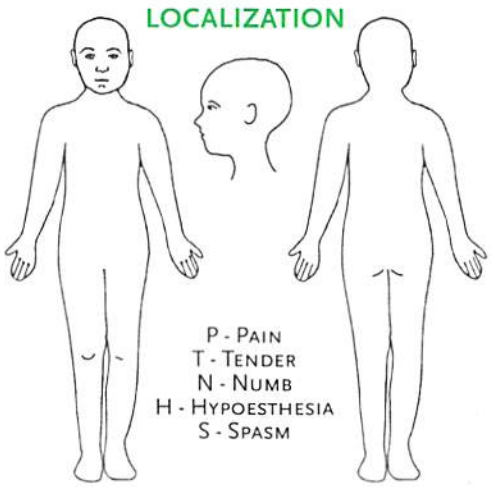
Prone - Short L R_____

Supine - Short L R_____

Derifield + - _____

X-RAY INTERPRETATION

LOCALIZATION



INSTRUMENTATION FINDINGS

☐ SEMG on file

Other_____

PEDIATRIC EXAMINATION

NEUROLOGICAL

Cerebral Function_____
Cerebellar Function_____
Brain Stem Function_____
Motor System Function_____

Cranial Nerves

I Olfactory_____
II Optic_____
III, IV, VI Eye Muscles_____
V Trigeminal_____
VII Facial_____
VIII Vestibulocochlear_____
IX Glossopharyngeal_____
X Vagus_____
XI Spinal Accessory_____
XII Hypoglossal_____

Infant Reflexes

Rooting	A	P
Sucking	A	P
Blink	A	P
Acoustic Blink	A	P
Moro	A	P
Galant's	A	P
Tonic Neck	A	P
Neck Righting	A	P
Palmer Grasp	A	P
Digital Response	A	P
Babinski Response	A	P
Vertical Suspension	A	P
Placing Response	A	P
Anal	A	P
Cremasteric	A	P

Reflexes

	L	R
Biceps	_____	_____
Triceps	_____	_____
Brachioradialis	_____	_____
Patellar	_____	_____
Achilles	_____	_____
Cremasteric	A	P
Abdominals	A	P

ORTHOPEDIC

	L	R
For. Comp. N_____		
Shoulder Dep._____		
Soto-Hall +/- _____		
Lasegue's_____		
Leg Drop +/- _____		
Fabere Pat._____		
Kernig's_____		
Trendelenburg_____		
Adam's_____		
Ely's_____		
Ortolani's_____		
Hip Exam_____		
Foot Flaring_____		
Internal	L	R B
External	L	R B

PHYSICAL

BP Lt._____ Rt._____
Lungs_____
Heart_____
Pulse_____
Temp._____
Resp._____
Abdomen_____
Eyes_____
Ears_____
Nose_____
Throat_____
Fontanelles_____
Lymphatic_____

ADDITIONAL TESTING

_____
_____
_____
_____
_____
_____
_____
_____

Clinical Comments

_____
_____
_____
_____
_____