HCW

Hornback Chiropractic & Wellness, P.A.

Pediatric Patient Information

Child's Name____

Mother's Name____ Date of Birth________________________

Father's Name____ Date of Birth________________________

Address____

City/Town ____State______________ Zip ____________

Home Phone( ) __________________________________

Mother's Work Phone( ) ___________________________ Mother's Cell Phone( ) ___________________________

E-Mail ____

Father's Work Phone( ) ___________________________ Father's Cell Phone( ) ___________________________

E-Mail ____

Birth Date____ Age______________________ Sex: ❏ M ❏ F

Birth Weight_______________________________________ Birth Length_______________

Current Weight_____________________________________ Current Length_____________

# of Siblings_______________________________________ Referred by______________________________________

Third Trimester Presentation

❏ Vertex ❏ Breech ❏ Transverse ❏ Face/Brow

Type of Birth

❏ Normal Vaginal ❏ Forceps ❏ Cesarean

❏ Suction Cup/Vacuum

Location

❏ Home ❏ Birthing Center ❏ Hospital

Problems During Pregnancy____

Problems During Labor/Delivery ____

Apgar scores____________________________ ________________________________

Was there a presence at birth of Jaundice (Yellow)?_______ Cyanosis (Blue)?___________

Congenital Anomalies/Defects?_________ If yes, please explain____

____

Infant Feeding ❏ Breast ❏ Bottle If bottle, which formula?____

Sleeping # Hours Sleeping/Night________________ **Quality of Sleep:** ❏ Good ❏ Fair ❏ Poor

Obstetrician/Midwife __________________________________ Pediatrician/Family M.D. ___________________________________

Date of Last Visit _____________________________________ Purpose of Visit ____

Immunization History

Doses of Antibiotics Your Child Has Taken: During the past 6 months____________ During his/her lifetime_____________

Prior Chiropractor ________________________________

Date of Last Visit ____________________ Purpose of Visit ____

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

Purpose of This Appointment ____

AUTHORIZATION FOR CARE OF MINOR
I HEREBY AUTHORIZE THIS OFFICE AND ITS DOCTORS TO ADMINISTER CARE AS THEY DEEM NECESSARY TO MY SON /DAUGHTER / WARD (UPON APPROVAL OF PARENT OR GUARDIAN).

Signature ____ Witness __________________________ Date __________________

www.hornbackchiro.com

Pediatric Case History

Delivery/Birth History ___________________________________

____

____

____

____

____

At what age did the child:
Respond to Sound ____________________________________

Follow an Object with Eyes _____________________________

Sit Alone ____

Hold Head Up _______________________________________

Crawl ____

Stand ____

Walk Independently ___________________________________

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

❑ Chickenpox _______________________________________

❑ Measles ____

❑ Mumps ____

❑ Rubella ____

❑ Rubeola ____

❑ Whooping Cough ___________________________________
Other ____

Has the child ever suffered the following spinal traumas ***(please check all that apply)*****?**

❑ Fall in Baby Walker ❑ Fall from Crib

❑ Fall from Changing Table ❑ Fall from Highchair

❑ Fall from Bed or Couch ❑ Fall off Slide

❑ Fall off Monkey Bars ❑ Fall off Swing

❑ Fall Down Stairs ❑ Fall off Bicycle

❑ Fall off Skates or Skateboard
Other

Has the child suffered from any of the following ***(please check all that apply)*****?**

❑ Behavioral Problems ❑ ADD/ADHD

❑ Headaches ❑ Dizziness

❑ Fainting ❑ Convulsions/Seizures

❑ Digestive Disorders ❑ Poor Appetite

❑ Ruptures/Hernia ❑ Muscle Pain

❑ Growing Pains ❑ Stomachaches

❑ Reflux ❑ Constipation

❑ Diarrhea ❑ Heart Trouble

❑ Chronic Earaches ❑ Sinus Trouble

❑ Asthma ❑ Colic

❑ Colds/Flu ❑ Broken Bones

❑ Scoliosis ❑ Backaches

❑ Poor Posture ❑ Orthopedic Problems

❑ Leg Problems ❑ Joint Problems

❑ Arm Problems ❑ Neck Problems

❑ Walking Trouble ❑ Bed Wetting

❑ Anemia ❑ Hypertension

❑ Diabetes

❑ Allergies to ______________________________

❑ Allergies to ______________________________

❑ Allergies to ______________________________

❑ Allergies to ______________________________

❑ Other ______________________________

❑ Other ______________________________

❑ Other ______________________________

Has the child ever sustained injuries resulting from an automotive accident? ❑ Yes ❑ No

If yes, please explain ______________________________

____

____

____

____

____

Has the child ever sustained an injury from playing organized sports? ❑ Yes ❑ No

If yes, please explain ______________________________

____

____

____

____

____

Present History ______________________________

____

____

____

Family History ______________________________

____

____

____

Surgery ______________________________

____

____

____

Medications ______________________________

____

____

____

Accidents ______________________________

____

____

____

Additional Notes ______________________________

____

____

____