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 I	LENGTH: CURRENT WEIGHT:	CURRENT LENGTH:
THIRD TRIMESTER PRESENTATION: VE	RTEXBREECHTRANSVERS	EFACE/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: WA	S THERE PRESENCE AT BIRTH OF: JAUNDICE (YELLOW)?	Cyanosis (Blue)?
CONGENITAL ANOMALIES/DEFECTS?	IF YES, PLEASE EXPLAIN?	
INFANT FEEDING: BREAST B	OTTLE IF BOTTLE, WHICH FORMULA?	
NUMBER OF HOURS SLEEPING PER NIC	SHT: QUALITY OF SLEEP: GOOD	FAIR POOR
OBSTETRICIAN/MIDWIFE:		
PEDIATRICIAN/FAMILY MD:		
DATE OF LAST VISIT:	PURPOSE:	
IMMUNIZATION HISTORY:		į.
NUMBER OF DOSES OF ANTIBIOTICS YOU	R CHILD HAS TAKEN: DURING THE PAST SIX MONTHS	DURING HIS/HER LIFETIME
Previous Chiropractor:		" College City
DATE OF LAST VISIT:	Purpose:	The Control of the Co
	ON AN EMERGENCY BASIS? IF YES, PLEASE EXPLA	IN:
PURPOSE OF THIS APPOINTMENT:		
Insurance/Billing Information:	Poli	cy #:
	AUTHORIZATION FOR CARE OF MI	NOR
I HEREBY AUTHORIZ	ZE THIS OFFICE AND ITS DOCTOR(S) TO ADMINISTER CARE AS T SON/DAUGHTER/WARD (UPON APPROVAL OF PARENT OR G	
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	