PEDIATRIC PATIENT HISTORY

Name of Child: _____ SS# _____
DOB: _____ Grade in School:_____ Gender: M / F Main Phone #: _____
Address: _____ City: _____ State: _____ Zip: _____
Mother's Name: _____ Main Phone #: _____
Father's Name: _____ Main Phone #: _____
Referred By: _____ Pediatrician: _____

Would you like Dr. Carlin to send her findings to update your Pediatrician? Y/N

It seems that patients greatly benefit when their health care providers work together.

Purpose of this Appointment: _____
_____
_____

Siblings & Ages: _____
Are mom and dad currently under chiropractic care? Y/ N Have the kids been adjusted before? Y/ N
How does this condition affect family members? _____
_____

Pregnancy History (Mother): (If child is adopted, answer to the best of your ability)
Did you experience any of the following during pregnancy:

- o Severe viral infection during pregnancy 1st trimester
- o Breech position during pregnancy
- o Accident or infections
- o Smoking
- o Severe stress
- o Pre-eclampsia
- o Alcohol consumption and or drug use
- o Radiation exposure
- o Hypertension (High Blood pressure)
- o Toxoplasmosis
- o Uncontrolled Diabetes
- o Toxemia

Labor and Delivery History: Did you experience any of the following during labor/delivery:

- o Hospital Birth
- o Birthing home
- o Long and/or difficult birth
- o Placenta previa
- o Forceps or suction cup used
- o Fetal distress
- o Elective C-section
- o The child was a "blue baby"
- o Home birth
- o Labor was induced
- o Delivery was rapid
- o Breech birth
- o Cord around the neck
- o Breech birth
- o Emergency C-section
- o The child was premature (2+ weeks)

Newborn History: Did the child experience any of the following as a newborn:

- o Required resuscitation/oxygen
- o Prolonged Jaundice
- o Poor sleeper
- o Immunizations in hospital
- o If yes, specify vaccine: _____ _____
- o Distorted Skull
- o Difficulty latching/sucking
- o Formula fed
- o Breast fed
- o Bottle fed
- o Colic
- o Weight at Birth:_____
- o Length at Birth:_____

Health History: Has your child ever experienced the following or been diagnosed as having any of the following:

- o Illness accompanied by a high fever
- o Frequent headaches
- o Chronic ear infections/earaches
- o Meningitis

Patient Name: _____ Date: _____

(continued)

- o Head injury
- o Serious Fall(s) or repetitive falls
- o Serious illness
- o Epilepsy/Seizures/Fainting
- o Meningitis
- o Allergies to foods
- o Environmental allergies
- o Chemical Insensitivities
- o Undergone any surgeries
- o Neck or back problems
- o Adverse reaction to any vaccinations (even if mild): _____
- o Diabetes
- o Hypoglycemia (low blood sugar)
- o Trouble with bladder control (enuresis)
- o Dizziness
- o High blood pressure
- o Heart disease
- o Asthma
- o Sinus problems
- o Constipation
- o Diarrhea
- o Digestive disorders
- o Rheumatic fever
- o Joint or muscle problems

Developmental History: Does or did your child have any of the following:

- o Difficulty with crawling (on all fours)
- o Difficulty learning to ride a bike
- o Difficulty learning to read
- o Difficulty using utensils
- o Difficulty tying shoes
- o Poor hand-eye coordination
- o At what age did your child learn to walk unassisted: _____
- o Did not crawl on all fours
- o Appears Clumsy
- o Difficulty with writing
- o Difficulty buttoning clothing
- o Difficulty or awkward with walking/running
- o Difficulty sitting still or paying attention

Neurological/Other: Has your child ever been diagnosed by a medical professional with any of the following, if yes, by whom:

- o Hearing loss or impairment
- o Neurological disorders
- o Obsessive Compulsive Disorder (OCD)
- o ADD/ADHD
- o Dyslexia
- o Visual impairment
- o Anxiety/Depression
- o Autism/Autism Spectrum Disorder
- o Tourette's Syndrome
- o Other: _____

Current/Past Medications and Treatment: List any medications that your child is taking: (List names, dose and frequency): _____

_____

_____

List any special dietary needs that your child has:_____

_____

List any supplements that your child takes:_____

_____

List any special services that your child is currently receiving at school or privately:_____

_____

List any special dietary needs that your child has:_____

_____

List any treatment that your child is currently undergoing with any health professional:_____

_____

PEDIATRIC PATIENT HISTORY

Patient Name: _____ Date: _____

List any previous chiropractic treatment, medications or other medical treatment that your child has undergone:_____
_____
_____
_____
_____

Comments: _____
_____
_____
_____
_____
_____
_____
_____

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AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize Dr. Stacy Carlin, DC, CACCP to evaluate and treat my son/daughter as she deems necessary.

I also acknowledge that I am financially responsible for any and all fees charged by this office and that payment will be made as services are provided. I also understand that any x-rays taken at this office are property of this clinic.

_____ _____
Signature and relation of person completing this form Date

_____ _____
Signature of Witness Date