PEDIATRIC PATIENT INTRODUCTION

'A' Street Clinic of Chiropractic, PLLC
Donald W. Olson, DC, FASBE, DACS, Auburn, WA

CHILD'S NAME: ____________________ HOME PHONE: ____________________

STREET ADDRESS: ____________________ APT/LOT NUMBER: ____________

CITY/TOWN: ____________________ STATE: ________ ZIP: ____________

MOTHER'S NAME: ____________________ MOTHER'S WORK PHONE: ____________

FATHER'S NAME: ____________________ FATHER'S WORK PHONE: ____________

BIRTH DATE: ______ ______ ______ AGE: _______ BIRTH WEIGHT: _________ CURRENT WEIGHT: ___________

SEX: ________ NO. OF SIBLINGS: __________ BIRTH LENGTH: ___________ CURRENT LENGTH: ___________

TYPE OF BIRTH: NORMAL VAGINAL _______ FORCEPS _______ BREECH _______ CESAREAN ________

HOME _______ BIRTHING CENTER _______ HOSPITAL _______

PROBLEMS DURING PREGNANCY: ____________________________________

PROBLEMS DURING LABOR/DELIVERY: ____________________________________

APGAR SCORES: _______ _______ WAS THERE PRESENCE AT BIRTH OF: __________ JAUNDICE (YELLOW)

__________ CYANOSIS (BLUE)

PURPOSE OF THIS APPOINTMENT: ____________________________________

HAS YOUR CHILD EVER BEEN TREATED ON AN EMERGENCY BASIS? ____________________

DESCRIBE: ____________________________________

ANY VACCINATIONS: ____________________________________

ANY VACCINATION REACTIONS: IMMEDIATE ____________ WITHIN FOLLOWING MONTH(S) ____________

CONGENITAL ANOMALIES/DEFECTS: ____________________________________

INFANT FEEDING: BREAST ______________ BOTTLE ______________ FORMULA ______________

NO. OF HOURS SLEEP PER NIGHT: ________ QUALITY OF SLEEP: GOOD ________ FAIR ________ POOR _______

OBSTETRICIAN/MIDWIFE: ____________________________________

LOCATED AT: ____________________________________

PEDIATRICIAN/FAMILY MD: ____________________________________

LOCATED AT: ____________________________________

DATE OF LAST VISIT TO MD: ____________________ PURPOSE: ____________________

INSURANCE/BILLING INFORMATION:____________________________________

____________________________________ POLICY NUMBER: ____________________

I REALIZE THAT I AM RESPONSIBLE FOR ALL FEES CHARGED BY THIS CLINIC AND THAT I WILL PAY FOR ALL SERVICES PERFORMED. X-RAYS REMAIN THE PROPERTY OF 'A' STREET CLINIC OF CHIROPRACTIC, PLLC

DATE: ____________________ SIGNATURE: ____________________________________

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1020 'A' St SE #4, Auburn WA 98002

PEDIATRIC CASE HISTORY

DEVELOPMENTAL 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

CHILDHOOD DISEASES: ________________ CHICKENPOX
________________ MUMPS
________________ MEASLES
________________ RUBELLA
________________ RUBEOLA
________________ WHOOPING COUGH

OTHER ILLNESSES: ____

HAS THIS CHILD EVER SUFFERED FROM:

❑ DIZZINESS	❑ BACKACHES	❑ HEART TROUBLE	❑ CHRONIC EARACHES
❑ DIABETES	❑ TUBERCULOSIS	❑ HYPERTENSION	❑ COLDS/FLU
❑ ARTHRITIS	❑ HEADACHES	❑ ASTHMA	❑ ALLERGIES
❑ NEURITIS	❑ DIGESTIVE DISORDERS	❑ SINUS TROUBLE	❑ CONSTIPATION
❑ ANEMIA	❑ RHEUMATIC FEVER	❑ ORTHOPEDIC PROBLEMS	❑ DIARRHEA
❑ POOR APPETITE	❑ HYPERACTIVITY	❑ SUGAR CONCENTRATION	❑ BEHAVIORAL PROBLEMS
❑ BED WETTING	❑ CONVULSIONS	❑ PARALYSIS	❑ MUSCLE JERKING
❑ FAINTING	❑ WALKING PROBLEMS	❑ BROKEN BONES	❑ RUPTURES/HERNIAS
❑ NECK PROBLEMS	❑ ARM PROBLEMS	❑ LEG PROBLEMS	❑ "GROWING PAINS"
❑ JOINT PROBLEMS	❑ BLOOD DISORDERS	❑ STOMACH ACHES	❑ OTHER ______________

PRESENT HISTORY: ____

____

____

____

SURGERY:____

____

MEDICATIONS:____

____

ACCIDENTS:____

____

FAMILY HISTORY:____

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AUTHORIZATION FOR CARE OF MINOR

I HEREBY AUTHORIZE THIS CLINIC AND IT'S DOCTOR(S) TO ADMINISTER CARE AS THEY SO DEEM NECESSARY TO MY SON / DAUGHTER / WARD (UPON APPROVAL OF PARENT OR GUARDIAN).

SIGNED: ____________________________ WITNESSED: ______________________ DATE: ______________