PEDIATRIC PATIENT INTRODUCTION

Child's Name: _____ Manitoba Health # _____ (6 digit) / _____ (9 digit)

Mother's Name: _____ Father's Name: _____

Address: _____
(Box/Street) (City) (Postal Code)

Phone: (Home) _____ Mother's Work #: _____ Cell #: _____

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

Birth Date: (m/d/y) _____ Age: ____ Sex: M F # of Siblings: _____ Referred by: _____

Birth Weight: (lbs) _____ Birth Length: (cm) _____ Current Weight: _____ Current Length: _____

Third Trimester Presentation: Vertex_____ Breech_____ Transverse_____ Face/Brow_____

Type of Birth: Normal Vaginal: _____ Forceps: _____ Cesarean: ____ Suction Cup/Vacuum: _____

Location: Home_____ Birth Center_____ Hospital_____

Problems During Pregnancy: _____

Problems During Labor/Delivery: _____

Apgar Scores: _____ _____ Presence at birth of: Jaundice (Yellow)_____ Cyanosis (Blue) _____

Congenital Anomalities/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: _____ Pediatricitan/Family MD: _____

Date of last Visit: _____ Purpose: _____

Immunization History: _____

# of Doses of Antibiotics your child has taken: Past 6 months: _____ Lifetime: _____

Previous Chiropractor: _____ Date of last visit: _____

Purpose: _____

Has your child ever been treated on Emergency Basis? Y N If Yes, Please explain: _____

_____

Purpose of this Appointment: _____

AUTHORIZATION FOR CARE OF MINOR

I HEREBY AUTHORIZE THIS OFFICE AND IT'S DOCTOR'S TO ADMINISTER CARE AS THEY SO DEEM NECESSARY TO MY CHILD (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 the child suffer from the following childhood diseases?

Chickenpox: _____ Mumps: _____ Measles: _____ Rubella: _____

Rubeola: _____ Whooping Cough: _____ Other: _____

Has this child ever suffered from:

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

Has this child ever sustained an injury playing organized sports? Y N If Yes, Please explain: _____

_____

□ Fall in a baby walker	□ Fall from bed/couch	□ Fall off skateboard/skates
□ Fall from crib	□ Fall off swing	□ Fall off bicycle
□ Fall from highchair	□ Fall off slide	□ Fall down Stairs
□ Fall from changing table	□ Fall of monkey bars	□ Other_____

Has this child ever sustained an injury playing organized sports? Y N If Yes, Please Explain: _____

_____

Has this child ever sustained an injury in an auto accident? Y N If Yes, Please Explain: _____

_____

Present History: _____

_____

Surgery: _____ Medication: _____

Accidents: _____ Family History: _____

_____