Pediatric Personal Information

First Name:___________________________ Last Name:_______________________________

Address:____

City:___________________ State:_____________________ Zip:_________________

Date Of Birth:_______________ Sex: Male ☐ Female ☐ Social Security #:_______________

Parent(s) Cell:____

E-mail Address:____

Parent(s)/Guardian(s) Name:____

Who may we thank for referring you?____

Emergency Contact, Name & Number:____

Parents Occupation:______________________ Parents Employer:_________________________

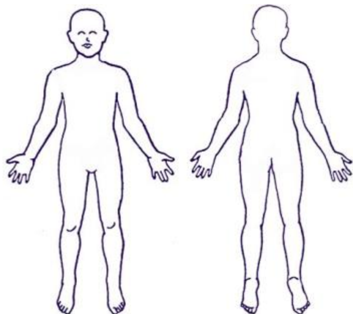
Health Insurance Company:____

Primary reason for contacting our office:____

Is this purpose of the visit related to: ☐Sports ☐ Auto ☐ Home Injury ☐ Fall

Date of Injury:_______________ if no Injury, when did the problem begin_________________

Please mark on diagram where your child is experiencing symptoms.



What makes it better:_________________

What makes it worse:_________________

Has this condition occurred before? _____

List any activities of daily living effected:______________________________

3233 S. Sycamore Ave. Sioux Falls, SD 57110
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Family Medical History Check any that apply.

☐ Cancer	☐ Heart Disease	☐ Asthma	☐ Diabetes	☐ Stroke
☐ Depression	☐ Allergies	☐ Seizures	☐ Other____________________	

Goals for Childs Care

Children see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of pain, others for correction of whatever is malfunctioning in their bodies and some for prevention and wellness. Your doctor will weigh your needs and desires when recommending a care program for your child. Please check the type of care the most closely describes the type of care you desire.

Relief- Symptomatic relief of pain or discomfort.

Corrective- Correcting and relieving the cause of the problem as well as the symptoms.

Prevention and Wellness- Regardless of symptoms we strive to restore neurologic balance and help your child reach and maintain their highest health potential.

Authorization to Care for a Minor Child

I hereby authorize the doctor to treat my child (name)__________________________as he/she deems appropriate through the use of, but not limited to, spinal adjustments.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. The doctor's office may bill my insurance as a courtesy to me and will prepare any necessary reports and forms (fees may apply) to assist in making collection from the insurance company. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment of all fees for service including legal fees, collection agency fees, and any other expenses incurred in collecting my account.

Patients Name (print)________________________________ Date_________________________

Parent/Legal Guardian Name (print)____

Signature: ____

Mothers Pregnancy and Labor

Childs birth was: ☐ At Home ☐ At a birthing center ☐ At a Hospital

My obstetrician/midwife/family physician was: ____________________________________

Birth Process: Natural vaginal (no medications/interventions) C-Section

Vaginal with interventions: (☐ Induction ☐ Pain meds ☐ epidural ☐ vacuum ☐ forceps)

Birth weight_________ Birth Height__________ Current Weight______ Current Height______

At what age did the child:

Respond to sound_____ Follow an object_____ Hold head up_____ Vocalize_____

Sit alone_____ Teethe_____ Crawl_____ Walk_____

Is/was your child breast fed? ☐ Yes ☐ No

Food sensitivities (please list)____

Did the mother smoke during pregnancy? ☐ Yes ☐ No

Did the mother drink alcohol during pregnancy? ☐ Yes ☐ No

Has the child received any vaccinations? ☐ Yes ☐ No

If yes, which ones and list any reactions. ____

Has the child received antibiotics ☐ Yes ☐ No if yes, how many times?______________

Any behavioral problems? ☐ Yes ☐ No If yes, please explain_________________________

Does your child seem normal for their age? ☐ Yes ☐ No If no, please explain

____

____

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Past Medical History (Check any that apply) Other:___________________________________

Vision Problems	Tubes in ears	Allergies	Hyperactivity	Breathing problems
Headaches	Drug reactions	Asthma	Ear Problems	Sleeping disorders
Attention Problems	Food reactions	Colic	Constipation	Frequent colds
Digestive problems	Environmental issues	Pink eye	Irritability	Skin Problems

Surgeries/Operations:____

Significant Traumas:____

Prescription and Over the Counter medications:______________________________________

Allergies: ☐Food ☐ Medication ☐ Environmental Please describe____________________

Signature of parent/legal guardian:____

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