Genesis Chiropractic Wellness & Rehabilitation Center

Pediatric Form

Name of Parent or Guardian:_____**Date**:_____
Name of Child:_____
Address:_____
City:_____**State**:_____**Zip**:_____
Home Phone:_____**Work Phone**:_____**Cell Phone**:_____
Would you like text reminders? NO/YES **Who is your cell phone carrier?**_____
Date of Birth:_____ **Gender**: Male/Female **Social Security Number**:_____
Race: American Indian, Asian, Black OR African American, Native Islander, White, Decline
Ethnicity: Hispanic/Latino, Non-Hispanic/Latino, Decline
Marital Status:_____ How did you hear about us?_____
Does Childs address or homephone differ from Patient or Gaurdian?
Yes/No List:_____

Does your child consume caffeine? No/Yes
Does your child consume alcohol? No/Yes
Does your child smoke? No/Yes
Does your child use drugs? No/Yes
Does your child exercise? No/Yes

Allergies: _____
_____
_____

List all Surgeries: _____
_____
_____

List all Medical History conditions:_____
_____
_____

List all Medications/Vitamins:_____
_____
_____

Family Health History: Please write down any/all medical histories below that apply to the following members:

Father:_____ **Mother:**_____
Brothers: _____ **Sisters:** _____

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Has you child ever had chiropractic care? No/Yes When:_____
Where:_____ **For what complaint?**_____

Reasons for seeking Chiropractic Care today:_____
_____
_____

Medical Doctor Information:

Who is your child's Pediatrician?_____
Name of the Clinic:_____
Date/Reason for last visit:_____

When doctors work together is benefits you and your child, do we have your permission to update your medical doctor regarding your child's care at this office? No/Yes

Have you consulted other medical professionals for the same condition that brings you to our facility? No/Yes
If yes, please specify other health care professionals your child has seen for this condition:_____
_____

Prenatal History:

Name of OB/Midwife:_____ **Was this pregnancy planned?** No/Yes
How far along were you when you found out you were pregnant?_____
Medications/Supplements taken PRE pregnancy:_____
Medications/Supplements taken DURING pregnancy:_____

Social History while Pregnant:
Did you: □Exercise Regularly □Eat a balanced Diet □Obtain sufficient rest
Did you smoke? No/Yes Packs/day_____
Did you drink alcohol? No/Yes Drinks/day_____
Did you drink caffeine? No/Yes Packs/day_____ What form (coffee, tea, etc)

Where there any complications during pregnancy? _____

Labor and Delivery:

Location of birth:_____
Birth interventions: □ Forceps □ Vacuum Extraction □ Epidural □ C-Section, planned or emergency?
Were there complications during delivery? No/Yes, explain:_____
Birth Weight:_____ **Birth Length**:_____ **APGAR score**:_____

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Feeding History:

Breast Feed: No/Yes How long?_____ **Formula Feed:** No/Yes How long?_____
Formula brand?_____
Does the baby prefer feeding on one side versus the other? No/Yes, if yes which side:_____
Introduced Solids at _____ months
Introduced cows milk at _____months
Food/drink Allergies, sensitiveness, or intolerances:_____

Has your child ever suffered from the following spinal traumas?
□ Fall in baby walker □Fall from bed or couch □Fall off swing □ Fall from highchair □Fall from crib
□ Fall down stairs □Fall off slide □Fall off changing table □Other:_____
_____

Vaccination History: □ Up to date □ Choose not to vaccinate □ Other:_____
Please describe any reactions to any vaccinations:_____

Does your child have trouble concentrating? No/Yes, please explain:_____
_____

Does your child get angry easily? No/Yes, if yes please explain:_____
_____

Does your child sleep through the night? No/Yes, if no how many hours:_____

Developmental Accomplishments

Gross Motor Skills:
□Holds head up from table momentarily
□Pushes up with hands and forearms
□Can be pulled into a sitting position by hands
□Sits unsupported in the upright position
□Rolls from back to belly
□Crawls
□Stands holding onto something
□Walks with someone holding onto one hand
□Walks unassisted
□Negotiates stairs placing 2 feet on each step
□Negotiates stairs placing 1 foot on each step
□Hops on 1 foot

Fine Motor Skills:
□Grabs your finger when placed in palm
□Holds and shakes a rattle placed in the left hand
□Grabs objects by him/her self
□Moves an object from one hand to the other
□Self feeding – can hold and eat food
□Checks objects by placing them in mouth
□Picks up objects with thumb and pointer finger
□Turns 2 to 3 pages of a book at the same time
□Turns 1 page of a book at a time
□Builds a tower containing at least 5 blocks
□Builds a tower containing at least 10 blocks

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Developmental Accomplishments

Social Skills:
- Smiles
- Reaches for familiar objects
- Plays with hands
- Plays with feet
- Clearly shows joy and pleasure
- Plays peak-a-boo
- Understands yes and no
- Laughs

Communication Skills:
- Makes cooing sounds
- Uses 1 syllable words such as “ma”
- Uses 2 syllable words such as “mama”
- Uses multiple words together to make a simple sentence such as “up mama”

Adaptive Skills:
- Holds his/her own bottle
- Drinks from a cup unassisted
- Feeds self with fingers
- Feeds self with spoon and fork
- Able to identify and match some colors
- Copies a circle
- Copies a cross

_____
Print name of Parent or Guardian

_____ _____
Signature of Parent or Guardian Date