LAKE
HEALTH + CHIROPRACTIC

Pediatrics

Child's name_____ Date of Birth_____

Address_____City_____ State_____

Zip Code_____ Parent(s)/guardian name _____

Cell Phone _____-_____-_____ Home Phone _____-_____-_____

What is the main reason for today's visit? _____

When did the problem start? _____

Is it getting better or worse with time? _____

Are there any factors that make it better or worse? _____

Where there significant falls or trauma to the mother during pregnancy? YES NO

If yes, please explain _____

Any evidence of birth trauma? ☐ Bruising ☐ Respiratory depression
☐ Cord around neck ☐ Stuck in birth canal
☐ unsure
☐ Fast/slow birth ☐ none
☐ Odd shaped head

Does the child have a history of serious falls or injuries (fractures, concussions, hospitalization) YES NO

If yes, please explain _____

Does your child wear a backpack? YES NO

If yes, is it a light or heavy backpack? _____

Does the child participate in sports or exercise activities? YES NO

If yes, please explain _____

Does the child engage in hobbies or activities that require prolonged repetitive posture? (ex: violin) YES NO

If yes, please explain _____

As an infant, was the child breast fed? YES NO

Was formula introduced? ☐ Yes, at _____ months and until _____ months ☐ No

Was cow's milk introduced? ☐ Yes, at _____ months ☐ No

Does the child have any food or liquid intolerances or allergies? YES NO UNKNOWN

If yes, please explain _____

During pregnancy, did the mother smoke? YES NO UNKNOWN

During pregnancy, did the mother drink alcohol? YES NO UNKNOWN

During pregnancy, did the mother use recreational drugs? YES NO UNKNOWN

Did the mother suffer any illnesses during pregnancy? YES NO UNKNOWN

If yes, please explain _____

Were nutritional supplements prescribed or taken during pregnancy? YES NO UNKNOWN

If yes, please explain _____

Were any invasive procedures performed during the pregnancy? YES NO UNKNOWN

If yes, please explain _____

Are there pets in the child's home? YES NO UNKOWN

If yes, please explain _____

Are there smokers in the child's home environment? YES NO UNKNOWN

Has the child had any adverse reactions to vaccines or medications? YES NO UNKNOWN

If yes, please explain _____

Is there a history of antibiotics given to the child? YES NO UNKNOWN

If yes, please explain _____

Have there been difficulties with parent-child bonding? YES NO UNKNOWN

If yes, please explain _____

Does the child have behavioral problems? YES NO UNKNOWN

If yes, please explain _____

Have any of the following behaviors occurred? (check all that apply below)

- ☐ Attention issues
- ☐ Bedwetting
- ☐ Difficulty sleeping
- ☐ Failure to maintain eye contact
- ☐ Hearing issues
- ☐ Nervous tics
- ☐ Night terrors
- ☐ Sleepwalking
- ☐ Stutter or stammer

On average, how many hours PER WEEK of television does the child watch? (check one below)

- ☐ Unsure
- ☐ 0-5 hours
- ☐ 6-10 hours
- ☐ 11-15 hours
- ☐ 16-20 hours
- ☐ 21-30 hours
- ☐ More than 30 hours

How many hours PER WEEK does the child spend watching his/her electronics? (check one below)

☐ Unsure ☐ 6-10 hours ☐ 16-20 hours ☐ More than 30 hours

☐ 0-5 hours ☐ 11-15 hours ☐ 21-30 hours

Do you feel the child's social and emotional development is normal for their age? YES NO UNKNOWN

Was there any delay in terms of the child's achievement of developmental goals? (check all that apply below)

☐ None, all developmental goals were met

☐ Delayed response to sound

☐ Delayed ability to follow an object

☐ Delayed ability to hold up head

☐ Delayed ability to vocalize

☐ Delayed ability to sit alone

☐ Delayed normal appearance of teeth

☐ Delayed ability to crawl

☐ Delayed ability to walk

Is there anything else you would like to discuss today?

_____

_____

CONSENT TO TREAT

I certify that I am the patient or the legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the information above to this office. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement or charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I am responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

Parent or guardian signature

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