



Name: _____

Today's Date: _____

Pediatric Personal Information

Full Legal Name _____ Preferred Name _____ Date of Birth: _____

Age: _____ Sex: Male Female Address: _____

City: _____ Zip: _____ Social Security # _____

Cell Phone () _____ - _____ Work/Home Phone () _____ - _____

E-mail Address _____

Parent(s)/Guardian(s) Name _____

What is the best way to contact you? Phone E-mail Text

Who may we thank for referring you? _____

Emergency Contact, Name & Phone # _____

Parents Occupation: _____ Parents Employer: _____

Parents Employer's Address: _____

Health Insurance Company: _____ Phone # _____

Health Insurance ID# _____ Group # _____

Primary Reason for Contacting Our Office _____

Mild Moderate Severe **Since onset is it:** Getting better Getting Worse Staying the Same

Is the purpose of the visit related to Sports Auto Home Injury Fall Wellness/prevention

Date of Injury: _____ If no injury, when did the problem begin _____

List any symptoms experienced (check more than one if necessary to describe the problem)

Sharp Dull Burning Numbness Tingling Pressure

Travels Constant Worst at Night Worst in Daytime

Please mark on diagram where you are experiencing symptoms

What makes it better _____

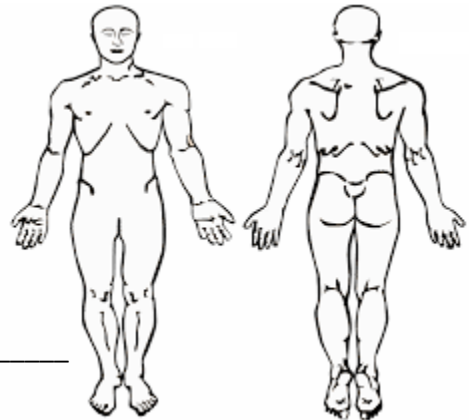
What makes it worse _____

Has this condition occurred before? Yes No

If yes, please explain _____

List any activities of daily living effected

Sleep School Daily Routine Other _____





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Mother's Pregnancy and Labor

Child's 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 (scheduled emergency)
 Vaginal with interventions (induction pain med epidural vacuum forceps)

Gestational age at birth _____ APGAR score at birth (if known) _____

Labor hours _____ Hours Pushing _____

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 If yes, how long _____ If no, age formula introduced _____

If cow's milk introduced, what age _____ Age child began eating solid foods _____

Food sensitivities (please list) _____

Did the mother smoke during pregnancy? Yes No

Did the mother drink alcohol during pregnancy? Yes No

List any drugs/medications (including over the counter) taken during pregnancy _____

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 _____

Past Medical History

List any that apply (mark with a [P] for past or [C] for current)

- Vision problems Tubes in the 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
- Other _____

Surgeries/Operations (type and date): _____

Significant Traumas: (include date): _____

Prescription and Over the Counter Medication (name and duration): _____

Allergies: Food Medication Environmental Please describe _____

Discover Chiropractic

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Family Medical History

List any that apply (*mark with a [F] for Father, [M] for Mother, [S] for Sibling or [G] for Grandparent*)

- Cancer Heart disease Asthma Diabetes Stroke Depression
- Allergies High Blood Pressure Seizures Other _____

Goals for Child's 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. I also understand and agree that if I suspend or terminate care any fees for services rendered to me will be immediately due and payable.

It is understood and agreed that any x-rays will remain property of this office, being on file where they may be seen at any time. The client also agrees that he/she is responsible for all bills incurred at this office. The doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

Patients Name (print) _____ Date _____

Parent/Legal Guardian Name (print) _____ Signature _____

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