DERRY CHIROPRACTIC

Pediatric Patient Information

Child's Name: _____ Today's Date_____

Date of Birth: _____ Age: _____ Gender: ☐ Male ☐ Female

Address: _____

Phone: _____ Email: _____

I would like to receive appointment reminders via: ☐ Email ☐ Text (Carrier:_____)

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

Whom may we thank for referring you? _____

Issues and Concerns

Reason for today's visit: _____

If your child has no symptoms or complaints and is here for wellness services, please check ☐

Since the problem started is it: ☐ About the Same ☐ Getting Better ☐ Getting Worse

What makes it worse?_____ What make it better?_____

It interferes with:☐ Sleep ☐ Eating ☐ School☐ Walking ☐ Sitting ☐ Other_____

Other Doctors seen for this problem:_____

Pregnancy, Birth, and Delivery

Where there any complications to the pregnancy?_____

_____

Was Mom on any prescription or over-the-counter medications during the pregnancy? ☐ No

☐ Yes. If yes, please list medications:_____

Did Mom or Dad smoke during the pregnancy? ☐ No. ☐ Yes. If yes, which parent? _____

Was the baby ever in the breech position: ☐ No. ☐ Yes. Number of Ultrasounds: _____

Where was the baby born? ☐ Hospital ☐ Birthing Center ☐ At Home ☐ Other:_____

Was the delivery: ☐ Vaginal ☐ C-Section Were any devices used? ☐ Forceps ☐ Vacuum

How long was Mom is labor? _____ How long was the actual delivery? _____

Was *oxytocin/pitocin* used? ☐ No ☐ Yes Was an epidural administered: ☐ No ☐ Yes

Infancy and Childhood

Was the child vaccinated? ☐ No ☐ Yes

Is the child on any medications? ☐ No ☐ Yes. If yes please list: _____

Has the child suffered any trauma such as a serious fall or car accident? ☐ No ☐ Yes

Has the child suffered any emotional trauma? ☐ No ☐ Yes. If yes please explain: _____

_____

Please list any surgeries the child has had: _____

Please provide any other health information you feel would be helpful: _____

_____

Consent for Treatment of a Minor

I have read and agree to the HIPAA privacy act information notice of privacy practices.

I hereby authorize Amy Trevey, D.C. to administer examinations and chiropractic care as deemed necessary for: Minor Patient's Name_____

Signature of Parent or Guardian: _____ Date: _____