

PEDIATRIC PATIENT INTRODUCTION FORM

INTRODUCTION

Date: _____

Patient name: _____

Address: _____

City, State, Zip: _____

Parent Email: _____

Birth date: _____ Age _____ Male Female

PARENT/GUARDIAN INFORMATION: (PLEASE CHECK PREFERRED METHOD OF CONTACT ABOVE)

Occupation: _____ Employer: _____ Employer Address: _____

Spouse: _____ S.S. # _____ Birth date: _____ Spouse Occupation: _____

Spouse Employer: _____ Employer Address: _____

PARENT/GUARDIAN INFORMATION: _____

S.S. # _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Who is responsible for your bill? Self Spouse Other Insurance Company: _____ Policy # _____

Referred by: _____

Previous Chiropractic Care: Yes No Date: _____ Doctor: _____

Were X-rays taken: Yes No Date: _____

Emergency Contact: _____ Phone: _____

MEDICAL HISTORY

Please list any/all medications your child is taking at this time and precise dosage per day in mg. Please include prescription drugs, over the counter medications, and any vitamins and supplements.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Please explain your child's current health challenge(s):

Please attach additional sheet if necessary.

PEDIATRIC HEALTH HISTORY 13-17 YEARS

We are excited that you have chosen Antoniotti Chiropractic to assist in the health and wellness needs of you and your family! Let us know if there is anything we can do to make you more comfortable. Please fill out this form as completely as possible so that we can provide the best possible care for your family.

PERSONAL INFORMATION

Child's Name: _____ What do you prefer to be called: _____

Home address: _____ City, State, Zip: _____

Age: _____ Date of Birth: ____/____/____ Male Female Weight: _____ Height: _____

Father's name: _____ Mother's name: _____

Father's Cell: _____ Mother's Cell: _____

Father's Work: _____ Mother's Work: _____

Home Phone: _____ E-mail address: _____

Parent's Marital Status: Single Married Separated Divorced Widowed Living Together

REASONS FOR SEEKING CHIROPRACTIC CARE

At Antoniotti Chiropractic, we focus on your child's ability to be healthy. Our goals are to first address the issues that brought your child to this office and second, to offer your child the opportunity of improved health, wellness, and quality of life in the future.

Please briefly describe the main concern that you would like Antoniotti Chiropractic to address for your child: _____

Are these concerns affecting your quality of life? (Check all that apply)

School Exercise/Sports Eating Sleep Hobby- please list _____ Other- please list _____

When did the issue start? _____ What brought it on? _____

Have you had this problem before? No Yes- please explain: _____

If you are experiencing pain, where is it located? _____

Describe the symptoms: Sharp Dull Achy Numb Tingling Stabbing Throbbing

Does the pain travel/radiate anywhere? No Yes- please explain: _____

Since the problem started, it is? About the same Getting Better Getting Worse

What makes it worse? Standing Walking Sitting Lying Bending Lifting Coughing Other

What have you done for this condition that has helped you feel better? _____

What have you done for this condition that was of no help? _____

Are you currently wearing: Heel lift R/L Arch supports

Other doctors seen for **this condition**: Chiropractor Medical Doctor Other- please list _____

1. Name: _____ City: _____ Date: _____ X-rays taken: Yes No

Special tests done: Yes No Diagnosis: _____ What was done: _____

2. Name: _____ City: _____ Date: _____ X-rays taken: Yes No

Special tests done: Yes No Diagnosis: _____ What was done: _____

Has your child ever had chiropractic care? Yes No Name of D.C. _____

How long under care? _____ days _____ weeks _____ months _____ years

Date of last visit: _____ Why was care stopped? _____ Are you satisfied with care received there? Yes No

Has your child consulted or does he/she regularly consult any of the following providers? (Check all that apply)

Medical Physician Neuropath Acupuncturist Homeopath Massage Therapist Psychotherapist Optometrist Dentist

Reason why: _____

Name of Pediatrician: _____ City: _____ Date of last visit: _____ Reason: _____

_____ Are you satisfied with care received there? Yes No

The primary system in the body, which coordinates health, is the CENTRAL NERVE SYSTEM. The vertebrae (bones of the spinal column) surround and protect the delicate NERVE SYSTEM. Chiropractors are specialists trained in "early detection" of injury to the SPINE & NERVE SYSTEM.

The information below will help us to see the types of PHYSICAL, CHEMICAL, & EMOTIONAL stresses your child has been subjected to and how they may relate to his/her present spinal, nerve, and health status.

GENERAL HISTORY:

Please mark all symptoms your child has ever had, even if they do not seem related to the current problem:

Ear infections Asthma ADHD Anemia Leg problems Orthopedic problem Constipation

Arm problems Sinus problems Seizures Allergies Recurrent fevers Reflux Diabetes Neck problems

Diarrhea Back problems Intestinal gas Chronic colds Digestive problems Colic Behavioral problems

Heart trouble Joint problems Poor appetite Trouble walking Other: _____

Please list any other **serious medical conditions** your child currently has or has ever had: _____

PHYSICAL STRESS:

Has your child ever suffered from the following **spinal traumas**?

Fall from bed or couch Fall off skates/skateboard Fall off bicycle Fall off swing Fall down stairs Fall off slide

Fall off monkey bars Other: _____

Has your child ever been involved in **organized sports** (i.e. football, soccer, baseball, basketball, gymnastics, cheerleading, etc.)? No Yes-

please explain: _____

Has your child ever been in a **car accident**? No Yes- please explain: _____

Has your child ever had a **bone fracture or joint dislocation**? No Yes- please explain: _____

Has your child had any **other traumas** not described above? No Yes- please explain: _____

Do you feel your child's **book bag** is too heavy for him/her? No Yes

How many hours per day does your child do each of the following?

Watch T.V. _____ Use a computer _____ Play video games _____

Does your child **sleep through the night**? Yes No- please explain: _____

On average, how many **hours of sleep** does your child get per night? _____

CHEMICAL STRESS:

Vaccination history: Up to date Chose to decline vaccinations Still deciding Other: _____

Please describe any adverse reactions to any vaccinations:

Number of **doses of antibiotics** your child has taken: During the past 6 months: _____ Total during lifetime: _____

Please list any **drugs or medications** (prescription or over-the-counter) your child is taking and the reason why:

Please list any **vitamins, supplements, herbs, homeopathies, etc.** that your child is taking and the reason why:

Do you have any concerns with your **child's diet**? No Yes- please explain: _____

EMOTIONAL STRESS:

Does your child have **difficulty concentrating**? No Yes- please explain: _____

Does your child complain of feeling **overwhelmed or frustrated**? No Yes- please explain: _____

Does your child get **angry easily**? No Yes- please explain: _____

ADDITIONAL QUESTIONS

If there is a need for dietary changes or nutrients, would you like to be informed? Yes No

If there is a need for specific exercises, would you like to be informed? Yes No

If there is a need for support in the emotional/stress area of health, would you like to be informed? Yes No

Is there any specific health topic you would like more information on? _____

EXPECTATIONS

I would like my child to have the following benefits from Antoniotti Chiropractic Care: (check all that apply)

- Relief of a symptom or problem
- Relief and prevention of a symptom or problem
- Healthier spine and nerve system
- Best possible health on all levels

PLEASE READ AND SIGN BELOW:

The information I have provided on these forms is correct and accurate to the best of my knowledge. I give Dr. _____ permission to administer care to my son/daughter, as they deem necessary. The initial visit includes a professional and complete health history/consultation and chiropractic examination/evaluation.

Patient Name

Date

Patient's Signature

Guardian or Spouse's Signature Authorizing Care

THANK YOU FOR CHOOSING ANTONIOTTI CHIROPRACTIC!
WE LOOK FORWARD TO HELPING YOU