ANTONIOTTI CHIROPRACTIC

1820 S. Westnedge Ave. Suite #1. Kalamazoo, MI 49008

269.344.5551 antoniottichiropractic.com

# PEDIATRIC PATIENT INTRODUCTION FORM

Date: _____

## INTRODUCTION

Patient name: _____

Address: _____

City, State, Zip: _____

Parent Email: _____

Birth date: _____ Age_____ Male ☐ Female ☐

PARENT/GUARDIAN INFORMATION:

S.S. # _____

Home Phone: _____☐

Work Phone: _____☐

Cell Phone: _____☐

(PLEASE CHECK PREFERRED METHOD OF CONTACT ABOVE)

PARENT/GUARDIAN INFORMATION:

Occupation: _____ Employer: _____ Employer Address: _____

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

Spouse Employer: _____ Employer Address: _____

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 attach additional sheet if necessary.

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

_____

_____

_____

_____

_____

ANTONIOTTI CHIROPRACTIC

1820 S. Westnedge Ave. Suite #1. Kalamazoo, MI

49008 269.344.5551 antoniottichiropractic.com

# PEDIATRIC HEALTH HISTORY
# INFANT TO 2 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 complete this form as much 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: _____

_____

## HEALTHCARE PRACTITIONER HISTORY

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

CHILD'S HEALTH PROFILE

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: _____

_____

## PARENTAL HISTORY:

Name of Obstetrician/Midwife: _____

Social history while pregnant:

Did you: ☐ Exercise regularly ☐ Eat a balanced diet ☐ Obtain sufficient rest

Did you: Smoke ☐ No ☐ Yes- How many packs per day? _____ Drink alcohol: ☐ Yes ☐ No- How many drinks per day? _____

Did you: Drink caffeine ☐ No ☐ Yes- In what form (coffee, tea, etc.) _____

Please list any medications/supplements taken while pregnant: _____

_____

Were there complications during pregnancy? ☐ No ☐ Yes- please explain: _____

Labor and Delivery:

Location of birth: ☐ Hospital ☐ Birthing Center ☐ Home Birth Intervention: ☐ Forceps ☐ Vacuum extraction ☐ Cesarean section

Were there complications during delivery? ☐ No ☐ Yes- please explain: _____

Birth weight: _____ Birth length (inches): _____ APGAR Scores: _____

## FEEDING HISTORY:

Breast-fed: ☐ No ☐ Yes- How long (months)? _____ Formula-fed: ☐ No ☐ Yes- How long (months)? _____ What brand? _____

Does the baby prefer feeding on one side more than the other? ☐ No ☐ Yes- Which side? _____

After feeding, does the baby frequently spit-up? ☐ No ☐ Yes Introduced to solids at _____ months-Introduced to cow's milk at _____ months

Food/Drink allergies, sensitivities, or intolerances: ☐ No ☐ Yes- please list: _____

_____

STRESSORS

## PHYSICAL STRESS:

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 ☐ Fall off monkey bars ☐ Other: _____

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: _____

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 get **angry easily**? ☐ No ☐ Yes- please explain: _____

_____

DEVELOPMENTAL ACCOMPLISHMENTS

Please check which skills your child can perform in each section:

### GROSS MOTOR SKILLS

☐holds head up from the table momentarily

☐pushes up with hands and forearms

☐can be pulled up into sitting position hands

☐sits unsupported in the upright position

☐rolls from back to belly

☐crawls

☐stand holding on to something

☐walks with someone holding

☐walks unassisted

☐runs

☐negotiates stairs placing 2 feet on each step

☐negotiates stairs placing 1 foot on each step

☐hops on 1 foot

### SOCIAL SKILLS

☐smiles

☐reaches for familiar

☐plays with hands

☐plays with feet

☐clearly shows joy and pleasure

☐feeds self with fingers

☐plays peek-a-boo

☐understands yes and no

### COMMUNICATION SKILLS

☐ makes cooing sounds

☐ laughs

☐uses 1 syllable words such as "ma"

☐uses 2 syllable words such as "mama"

### ADAPTIVE SKILLS

☐drinks from a cup unassisted

☐holds own bottle

☐feeds self with spoon and fork

☐able to identify and match same colors

☐copies a circle

### FINE MOTOR SKILLS

☐grabs your finger when put in palm ☐holds and shakes a rattle placed in the hand ☐grabs objects by him/her self

☐moves an object from one hand to the other ☐self-feeding: can hold and eat a cracker ☐checks objects by placing them in the mouth

☐picks up object 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

## 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