

HCW

HORNBACK CHIROPRACTIC
■■■ & WELLNESS, P.A. ■■■

Pediatric Patient Information

Child's Name _____

Mother's Name _____ Date of Birth _____

Father's Name _____ Date of Birth _____

Address _____

City/Town _____ State _____ Zip _____

Home Phone () _____

Mother's Work Phone () _____ Mother's Cell Phone () _____

E-Mail _____

Father's Work Phone () _____ Father's Cell Phone () _____

E-Mail _____

Birth Date _____ Age _____ Sex: M F

Birth Weight _____ Birth Length _____

Current Weight _____ Current Length _____

of Siblings _____ Referred by _____

Third Trimester Presentation

Vertex Breech Transverse Face/Brow

Type of Birth

Normal Vaginal Forceps Cesarean

Suction Cup/Vacuum

Location

Home Birthing Center Hospital Type _____

Problems During Pregnancy _____

Problems During Labor/Delivery _____

Apgar scores _____

Was there a presence at birth of Jaundice (Yellow)? _____ Cyanosis (Blue)? _____

Congenital Anomalies/Defects? _____ If yes, please explain _____

Infant Feeding Breast Bottle If bottle, which formula? _____

Sleeping # Hours Sleeping/Night _____ Quality of Sleep: Good Fair Poor

Obstetrician/Midwife _____ Pediatrician/Family M.D. _____

Date of Last Visit _____ Purpose of Visit _____

Immunization History

Doses of Antibiotics Your Child Has Taken: During the past 6 months _____ During his/her lifetime _____

Prior Chiropractor _____

Date of Last Visit _____ Purpose of Visit _____

Has your child ever been treated on an emergency basis? If yes, please explain _____

Purpose of This Appointment _____

AUTHORIZATION FOR CARE OF MINOR

I HEREBY AUTHORIZE THIS OFFICE AND ITS DOCTOR(S) TO ADMINISTER CARE AS THEY DEEM NECESSARY TO MY SON/DAUGHTER/ WARD (UPON APPROVAL OF PARENT OR GUARDIAN).

Signature _____ Witness _____ Date _____

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Pediatric Case History

Delivery/Birth History _____

- Fall from Changing Table
- Fall from Highchair
- Fall from Bed or Couch
- Fall off Slide
- Fall off Monkey Bars
- Fall off Swing
- Fall Down Stairs
- Fall off Bicycle
- Fall off Skates or Skateboard
- Other _____

At what age did the child:
Respond to Sound _____
Follow an Object with Eyes _____
Sit Alone _____
Hold Head Up _____
Crawl _____
Stand _____
Walk Independently _____

Has the child suffered from any of the following
(please check all that apply) ?

- Behavioral Problems
- ADD/ADHD
- Headaches
- Dizziness
- Fainting
- Convulsions/Seizures
- Digestive Disorders
- Poor Appetite
- Ruptures/Hernia
- Muscle Pain
- Growing Pains
- Stomachaches
- Reflux
- Constipation
- Diarrhea
- Heart Trouble
- Chronic Earaches
- Sinus Trouble
- Asthma
- Colic
- Colds/Flu
- Broken Bones
- Scoliosis
- Backaches
- Poor Posture
- Orthopedic Problems
- Leg Problems
- Joint Problems
- Arm Problems
- Neck Problems
- Walking Trouble
- Bed Wetting
- Anemia
- Hypertension
- Diabetes

At what age, if ever, did the child suffer from the following
childhood diseases?
 Chickenpox _____
 Measles _____
 Mumps _____
 Rubella _____
 Rubeola _____
 Whooping Cough _____
Other _____

Has the child ever suffered the following spinal traumas
(please check all that apply) ?

- Fall in Baby Walker
- Fall from Crib

- Allergies to _____
- Allergies to _____
- Allergies to _____
- Allergies to _____
- Other _____
- Other _____
- Other _____

Has the child ever sustained injuries resulting from an automotive accident? Yes No
If yes, please explain _____

Has the child ever sustained an injury from playing organized sports? Yes No
If yes, please explain _____

Present History _____

Family History _____

Surgery _____

Medications _____

Accidents _____

Additional Notes _____
