



Pediatric Patient Information

Personal history completed by: \_\_\_\_\_

Childs Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Current Age: \_\_\_\_\_

Mothers Name: \_\_\_\_\_ Father's Name: \_\_\_\_\_

Legal Guardian: \_\_\_\_\_

Patient's Personal Physician: \_\_\_\_\_ Type of Dr. \_\_\_\_\_

Whom can we thank for referring you: \_\_\_\_\_

I understand and agree that health insurance policies are an arrangement between and insurance carrier and myself. I understand that SLO WELLNESS CENTER (Stevens Chiropractic, Inc or Sachs Chiropractic, Inc). will prepare any necessary forms to assist in collection from the insurance company. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment at the time of services.

Guardian

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Consent to Treatment of a Minor**

I hereby authorize Dr. Stevens or Dr. Sachs and whomever he/she so designate as their assistant, to administer chiropractic care as he/she deems necessary to my son/daughter, \_\_\_\_\_, dated at San Luis Obispo this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

Signature: \_\_\_\_\_ Witnessed: \_\_\_\_\_

**In Case of Emergency**

Name of relative or close friend not living in your home: \_\_\_\_\_

Contact phone number: \_\_\_\_\_

### Health History

Birth Weight \_\_\_\_\_ Birth Length \_\_\_\_\_  
Current Weight \_\_\_\_\_ Current Length \_\_\_\_\_  
Sex M F Siblings \_\_\_\_\_

### Third Trimester Presentation

Vertex Breech  Transverse  Face/Brow

### Type of Birth

Vaginal  Vaginal-Induced  Forceps  Cesarean  Vacuum

### Location

Home  Birthing Center  Hospital

Please explain any problems experienced during Pregnancy

\_\_\_\_\_

Please explain any problems experienced during labor/delivery:

\_\_\_\_\_

Number of weeks of gestation:  Pre-Term # weeks \_\_\_\_\_  Full Term

Was there a presence at birth of:

Jaundice (yellow) \_\_\_\_\_ Cyanosis (Blue) \_\_\_\_\_ Congenital Anomalies \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

### Infant Feeding

Breast  Bottle, If bottle, which formula? \_\_\_\_\_

At what age was child introduced to solid foods: \_\_\_\_\_ Any negative reactions? \_\_\_\_\_

Estimate courses of anti-biotics during 1<sup>st</sup> year of life: \_\_\_\_\_ Total since birth: \_\_\_\_\_

How many bowel movements/ day on average?  Freq. constipated  1  2  3  >3

Vaccinations:  None  Some \_\_\_\_\_  All Vaccinations up to date for age

Any reactions: \_\_\_\_\_

At what age did child:

Sit up: \_\_\_\_\_ Crawl: \_\_\_\_\_ Walk: \_\_\_\_\_

Does child have unexplained rashes or itching? \_\_\_\_\_

Does child have dry skin or eczema? \_\_\_\_\_

Does child get headaches? \_\_\_\_\_

**HAS CHILD (not a family member) EVER BEEN DIAGNOSED WITH**

- ADD or ADHD Never Past Yes: \_\_\_\_\_
- Allergies/Hay fever Never Past Yes: \_\_\_\_\_
- Asperger's syndrome (AS) Never Past Yes: \_\_\_\_\_
- Asthma Never Past Yes: \_\_\_\_\_
- Anemia Never Past Yes: \_\_\_\_\_
- Autism Never Past Yes: \_\_\_\_\_
- Bladder/Urine Infection (UTI) Never Past Yes: \_\_\_\_\_
- Blood Pressure Problems Never Past Yes: \_\_\_\_\_
- Bronchitis/Pneumonia Never Past Yes: \_\_\_\_\_
- Colitis/Crohn's Disease Never Past Yes: \_\_\_\_\_
- Croup Never Past Yes: \_\_\_\_\_
- Cystic Fibrosis Never Past Yes: \_\_\_\_\_
- Developmental Delay Never Past Yes: \_\_\_\_\_
- Diabetes Type I (Juvenile Diabetes) Never Past Yes: \_\_\_\_\_
- Dysentery/Food Poisoning Never Past Yes: \_\_\_\_\_
- Dyslexia Never Past Yes: \_\_\_\_\_
- Ear Infection (Otitis Media) Never Past Yes: \_\_\_\_\_
- Easy Bruising Never Past Yes: \_\_\_\_\_
- Eating Disorder Never Past Yes: \_\_\_\_\_
- Eczema/Psoriasis – Skin Problems Never Past Yes: \_\_\_\_\_
- Enlarged Heart Never Past Yes: \_\_\_\_\_
- Epilepsy (Seizures) Never Past Yes: \_\_\_\_\_
- Gastric Reflux or Ulcers Never Past Yes: \_\_\_\_\_
- Goiter Never Past Yes: \_\_\_\_\_
- Heart Murmur/Arrhythmia Never Past Yes: \_\_\_\_\_
- Hemochromatosis (Iron Overload) Never Past Yes: \_\_\_\_\_
- Hepatitis/Jaundice Never Past Yes Hep A Hep B Hep C
- Hives Never Past Yes: \_\_\_\_\_
- Hyperthyroidism Never Past Yes: \_\_\_\_\_
- Hypothyroidism Never Past Yes: \_\_\_\_\_
- Irritable Bowel (IBS) Never Past Yes: \_\_\_\_\_
- Juvenile Rheumatoid Arthritis Never Past Yes: \_\_\_\_\_
- Kidney Infection Never Past Yes: \_\_\_\_\_
- Kidney Stones Never Past Yes: \_\_\_\_\_
- Learning Disorder Never Past Yes: \_\_\_\_\_
- Lyme Disease Never Past Yes: \_\_\_\_\_
- Meningitis Never Past Yes: \_\_\_\_\_
- Mental Retardation Never Past Yes: \_\_\_\_\_
- Migraine Headaches Never Past Yes: \_\_\_\_\_
- Mononucleosis Never Past Yes: \_\_\_\_\_
- Multiple Sclerosis (MS) Never Past Yes: \_\_\_\_\_
- Obsessive Compulsive Disorder (OCD) Never Past Yes: \_\_\_\_\_
- Pervasive developmental disorder Never Past Yes: \_\_\_\_\_
- Pharyngitis Never Past Yes: \_\_\_\_\_
- Sinusitis Never Past Yes: \_\_\_\_\_
- Speech Delay Never Past Yes: \_\_\_\_\_
- Strep Throat Never Past Yes: \_\_\_\_\_
- Syphilis/Chlamydia/STD Never Past Yes: \_\_\_\_\_
- Tourette's Never Past Yes: \_\_\_\_\_
- Yeast Infections Never Past Yes: \_\_\_\_\_
- Other \_\_\_\_\_
- Other \_\_\_\_\_

**ALLERGIES:**

Is child SENSITIVE/INTOLERANT/ALLERGIC to any of the following foods?

**DIET:**

Milk/Dairy    Wheat/Gluten    Peanuts    Soy    Eggs    Corn    Yeast    Chocolate    Citrus  
Fish/Shellfish    Strawberries

Other: \_\_\_\_\_

How many meals plus snacks per day does child eat on average?    1    2    3    4    5    Graze

Does child eat fruits and vegetables?    Frequently    Rarely    Almost Never

How many times/week, on average, does child eat Fish/Seafood?    More than 3    Rarely 1 – 2X/Wk  
Almost Never

Which Fats/Oils does child consume?

Butter    Olive Oil    Coconut Oil    Flax Oil    Safflower Oil    Sunflower Oil    Peanut Oil  
Grape Seed Oil    Macadamia Oil  
Mayonnaise    Margarine    Crisco    Corn Oil    Soybean Oil    Canola Oil

Is Child in any special diet?

Dairy-Free    Wheat/Gluten-Free    Yeast-Free    Feingold    Low Carbohydrate    High Protein  
No Special Diet

Other: \_\_\_\_\_

Do you live with any pets?    No    Yes

Describe \_\_\_\_\_

Please list any allergies that your child has been diagnosed with or that you suspect. \_\_\_\_\_

Does anyone in the home smoke?    Never    No    Yes    Type: Cigarettes    Cigars    Pipes

Other \_\_\_\_\_ Number/day: \_\_\_\_\_

**MEDICATIONS:** Is child currently taking (or recently discontinued) any PRESCRIBED medications?

Please List

\_\_\_\_\_

**OPERATIONS AND HOSPITALIZATIONS:**    No    Yes

Yr/Description \_\_\_\_\_

**DEVICES:** Please circle any of the following that the child utilizes:

Ear Tubes, Eyeglasses, Contact Lenses, Dental Braces, Back Brace, Knee Brace, Neck Brace, Implants, and/or Shunt.

How is child's dental health?    Excellent    Good    Fair    Poor

Has child had EYE exam? No Yes Date Last  
Exam \_\_\_\_\_

Has child had HEARING exam? No Yes Date Last  
Exam \_\_\_\_\_

**TESTS:** Has child ever had an X-ray, CAT-Scan, MRI, Sonogram, PET-scan, EKG or Bone Scan (circle which test ) of:

No Yes  
Yr/Test/Result \_\_\_\_\_

List all vitamins, minerals, herbs, amino acids, and nutritional supplements (with dose) you are taking on a regular basis:

- |          |          |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

**MAIN REASON AND GOALS OF APPOINTMENT:**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_