PEDIATRIC REGISTRATION AND HISTORY

*(FOR PATIENT AGES BIRTH-12)

PATIENT INFORMATION

PATIENT NAME: _____

Preferred Name/Nickname: _____

Sex at Birth: Male / Female

Address: _____

City: _____ State:_____ Zip:_____

Date of Birth: _____ Age:_____

Parent(s)/Guardian Name:

1)_____

phone#_____ Email: _____

Relationship to Child: _____

2)_____

phone#_____ Email: _____

Relationship to Child: _____

Grandparents or other adults who have legal authority to authorize care: _____

Phone#:_____

*Please see consent forms for custodial matters pertaining to care

INSURANCE / PAYMENT INFORMATION

SELF PAY: ____

COST SHARING PLAN: _____

INSURANCE COMPANY: _____

_____

ID #: _____

GROUP#: _____

POLICY HOLDER: _____

RELATIONSHIP TO PATIENT:_____

SECONDARY POLICY: _____

ID #: _____

GROUP#: _____

WHO IS RESPONSIBLE PARTY FOR BILLING: _____

_____

Patient/Guardian understands that, ultimately, the patient/guardian is responsible for all charges. We are happy to assist and file insurance claims for our patients. Patient/guardian authorizes release of all information regarding the records if needed.

_____ Initials

REFERRAL INFORMATION

Whom May We Thank for Referring You/Your Child?

_____

If this is a healthcare provider, do we have your permission to share information with them about you? Yes / No

Phone number of office: _____

PATIENT CONDITION

What is the reason for contacting us today?

_____

_____

_____

Onset: _____

PRENATAL HISTORY *FOR PATIENT AGES BIRTH- 3

Name of Obstetrician/Midwife: _____

Complications During Pregnancy? Yes / No IF YES: _____

Was this pregnancy considered High Risk? _____

Number of Ultrasounds During Pregnancy: _____ Tobacco/Alcohol/Drug Usage in Pregnancy? _____

Birth Interventions? ____ Forceps _____Vacuum Extraction _____ C-section _____ If yes: emergency? _____ planned_____

Complications During Delivery? Yes / No IF YES: _____

Genetic Disorders or Disabilities? Yes / No IF YES: _____

Birth Weight: _____ lbs Birth Length: _____ in. APGAR SCORES (if known) _____, _____

Did the patient spend any time in NICU? Yes / No IF YES: _____

Does the patient have any siblings? Yes / No Number? _____ Ages: _____

HEALTH HISTORY

DOES THE CHILD HAVE A PEDIATRICIAN? YES / NO If yes: _____

VACCINATION HISTORY:

THE DOCTORS AT ABUNDANT LIFE CHIROPRACTIC SUPPORT PARENTS' CHOICE AND MEDICAL FREEDOM AND SUPPORT ALL DECISIONS THAT PARENTS HAVE MADE.

CHILD HAS / HAS NOT RECEIVED VACCINATIONS. IF YES ? FULL SCHEDULE_____ ALTERED SCHEDULE _____

CHECK ANY OF THE FOLLOWING CONDITIONS YOUR CHILD HAS SUFFERED FROM:

ADHD		EAR INFECTIONS		COLIC/GAS	
SCOLIOSIS		SEIZURES		CHRONIC INFECTIONS	
ECZEMA		BED WETTING		GROWING PAINS	
BACK OR NECK PAIN		HEADACHES		NURSING/FEEDING PROBLEMS	
BEHAVIORAL PROBLEMS:				SLEEPING PROBLEMS	
LEARNING PROBLEMS:				ASTHMA	
ALLERGIES:				FUSSINESS	
DELAYED MILESTONES:				OTHER:	

TRAUMAS:

SURGERIES:

FRACTURES/DISLOCATIONS:

CANCERS (FOR THEM):

PREVIOUS CHIROPRACTIC CARE? YES / NO IF YES, DOCTOR NAME: _____

WERE YOU SATISFIED WITH THE CARE YOUR CHILD RECEIVED? YES / NO

MEDICATION/SUPPLEMENT HISTORY

NUMBER OF DOSAGES OF ANTIBIOTICS YOUR CHILD HAS TAKEN: DURING THE PAST 6 MONTHS_____ TOTAL_____

NUMBER OF DOSAGES OF OTHER PRESCRIPTION MEDICATIONS: DURING THE PAST 6 MONTHS_____ TOTAL_____

CURRENT MEDICATIONS? YES / NO IF YES: _____

CURRENT SUPPLEMENTS/VITAMINS? YES / NO IF YES: _____

FEEDING HISTORY *(FOR CHILDREN AGES BIRTH- FIVE)*

BREASTFED: YES / NO IF YES, HOW LONG? _____ CURRENTLY____

FORMULA FED: YES / NO IF YES, HOW LONG? _____ CURRENTLY____

TONGUE/LIP TIES: YES / NO IF YES, REVISED? YES / NO

WHEN? _____ BY WHOM? _____

DIFFICULTY WITH FEEDING? YES / NO IF YES, DESCRIBE: _____

AGE INTRODUCED SOLIDS? _____

CHILDHOOD DISEASES (CHECK ANY)

CHICKEN POX: YES / NO AGE: _____

MEASLES: YES / NO AGE: _____

MUMPS: YES / NO AGE: _____

WHOOPING COUGH/PERTUSSIS

YES / NO AGE: _____

RUBELLA: YES / NO AGE: _____

RUBEOLA: YES / NO AGE: _____

OTHER:

DEVELOPMENTAL HISTORY AND MILESTONES

AT WHAT AGE WAS YOUR CHILD ABLE TO (ANSWER IF KNOWN): CHECK IF ITEM WAS DONE WITHIN A NORMAL TIME FRAME

RESPOND TO SOUND/VISUAL STIMULI? _____HOLD HEAD UP? _____

ROLL? _____

DID YOUR CHILD ROLL TUMMY TO BACK? YES / NO BOTH WAYS? YES / NO _____

DID YOUR CHILD ROLL BACK TO TUMMY? YES / NO BOTH WAYS? YES / NO _____

SIT UP ON OWN? _____

CRAWL: _____ DID YOUR CHILD HAVE A CROSS CRAWL PATTERN? YES / NO OTHER : _____

CRUISE FURNITURE/OBJECTS? _____ STAND ON OWN? _____ WALK? _____

ANY OTHER CONCERNS: YES / NO IF YES:

I AGREE THAT I HAVE ANSWERED ALL QUESTIONS ACCURATELY TO THE BEST OF MY ABLITY.

PARENT/GUARDIAN SIGNATURE: DATE: