Kambeitz Chiropractic
Health & Wellness Center, P.C.
Empowering you to live your best life.

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PEDIATRIC PATIENT INFORMATION

PATIENT NAME: ______________________________

DATE OF BIRTH: ________ /______ /______ SEX: ☐ MALE ☐ FEMALE ☐ OTHER SSN: XXX-XX-__________

BIRTH WEIGHT: __________ BIRTH HEIGHT: __________ CURRENT WEIGHT: __________ CURRENT HEIGHT: __________

CASE NUMBER: ______________________ REFERRED BY: ______________________

PATIENT ADDRESS: ______________________ CITY: ______________ STATE: ________ ZIP: ________

HOME PHONE:______________________ EMAIL:______________________

MOTHER'S NAME: ______________________ DOB: ______________

MOTHER'S CELL PHONE: ______________________ MOTHER'S WORK PHONE: ______________________

FATHER'S NAME: ______________________ DOB: ______________

FATHER'S CELL PHONE: ______________________ FATHER'S WORK PHONE: ______________________

PREGNANCY AND DELIVERY INFORMATION

THIRD TRIMESTER PRESENTATION: VERTEX __________ BREECH __________ TRANSVERSE __________FACE/BROW __________

TYPE OF BIRTH: ☐ NORMAL VAGINAL ☐ FORCEPS ☐ CESAREAN ☐ SUCTION CAP OR VACUUM

LOCATION: ☐ HOME ☐ BIRTHING CENTER ☐ HOSPITAL

PROBLEMS DURING PREGNANCY ______________________________

PROBLEMS DURING LABOR/DELIVERY: ______________________________

APGAR SCORES: _____ _____ WAS THERE PRESENCE AT BIRTH OF: JAUNDICE (YELLOW)?__________ CYANOSIS (BLUE)?________

CONGENITAL ANOMALIES/DEFECTS?_____ IF YES, PLEASE EXPLAIN? ______________________________

DELIVERY/BIRTH HISTORY: ______________________________

____

____

____

MEDICAL INFORMATION

INFANT FEEDING: ☐ BREAST ☐ BOTTLE IF BOTTLE , WHICH FORMULA?______________________

NUMBER OF HOURS SLEEPING PER NIGHT: ______________ QUALITY OF SLEEP: ☐ GOOD ☐ FAIR ☐ POOR

OBSTETRICIAN/MIDWIFE:______________________ PEDIATRICIAN/FAMILY MD:______________________

DATE OF LAST VISIT: ______ /_____ /______ REASON: ______________________

IMMUNIZATION HISTORY: ______________________________

NUMBER OF DOSES OF ANTIBIOTICS YOUR CHILD HAS TAKEN: IN THE PAST 6 MONTHS _____ IN THEIR LIFETIME ______

PREVIOUS CHIROPRACTOR: ______________________________

DATE OF LAST VISIT: ______ /_____ /______ REASON: ______________________

HAS YOUR CHILD EVER BEEN TREATED ON AN EMERGENCY BASIS? _____ IF YES, PLEASE EXPLAIN: ______________

PEDIATRIC CASE HISTORY

AT WHAT AGE DID THE CHILD:

RESPOND TO SOUND: ________ FOLLOW AN OBJECT WITH THEIR EYES:________ HOLD HEAD UP ________

SIT ALONE: ________ CRAWL: ________ STAND : ________ WALK ALONE: ________

HAS YOUR CHILD EVER SUFFERED FROM THE FOLLOWING CHILDHOOD DISEASES? IF YES, AT WHAT AGE.

☐ CHICKENPOX ______	☐ MUMPS ______	☐ MEASLES ______	☐ OTHER ______
☐ RUBEOLA ______	☐ WHOOPING COUGH ______	☐ RUBELLA ______	☐ OTHER ______

HAS YOUR CHILD EVER SUFFERED FROM:

☐ HEADACHES	☐ ORTHOPEDIC PROBLEMS	☐ DIGESTIVE DISORDERS	☐ BEHAVIORAL PROBLEMS
☐ DIZZINESS	☐ NECK PROBLEMS	☐ POOR APPETITE	☐ ADD/ADHD
☐ FAINTING	☐ ARM PROBLEMS	☐ STOMACH ACHES	☐ RUPTURES/HERNIA
☐ SEIZURES/CONVULSIONS	☐ LEG PROBLEMS	☐ REFLUX	☐ MUSCLE PAIN
☐ HEART TROUBLE	☐ JOINT PROBLEMS	☐ CONSTIPATION	☐ GROWING PAINS
☐ CHRONIC EARACHES	☐ BACKACHES	☐ DIARRHEA	☐ ALLERGIES TO ______
☐ SINUS TROUBLE	☐ POOR POSTURE	☐ DIABETES	☐ ALLERGIES TO ______
☐ ASTHMA	☐ SCOLIOSIS	☐ HYPERTENSION	☐ ALLERGIES TO ______
☐ COLDS/FLU	☐ WALKING TROUBLE	☐ ANEMIA	☐ OTHER ______
☐ COLIC	☐ BROKEN BONES	☐ BED WETTING	☐ OTHER ______

HAS YOUR CHILD SUFFERED FROM THE FOLLOWING SPINAL TRAUMAS?

☐ FALL IN BABY WALKER	☐ FALL FROM BED OR COUCH	☐ FALL OFF SKATEBOARD OR SKATES
☐ FALL FROM CRIB	☐ FALL OFF SWING	☐ FALL OFF BICYCLE
☐ FALL FROM HIGHCHAIR	☐ FALL OFF SLIDE	☐ FALL DOWN STAIRS
☐ FALL FROM CHANGING TABLE	☐ FALL OFF MONKEY BARS	☐ OTHER ______

HAS YOUR CHILD EVER SUSTAINED AN INJURY PLAYING ORGANIZED SPORTS?______ IF YES, PLEASE EXPLAIN:________________

____

HAS YOUR CHILD EVER SUSTAINED INJURIES IN AN AUTO ACCIDENT? ________ IF YES, PLEASE EXPLAIN:________________

____

PRESENT HISTORY:________________________________

SURGERY: ________________________________

MEDICATIONS: ________________________________

ACCIDENTS: ________________________________

FAMILY HISTORY:________________________________

INSURANCE INFORMATION

PRIMARY INSURANCE INFORMATION PLAN NAME: ________________________

POLICY HOLDER: ________________ EFFECTIVE DATE: ________________

INSURANCE ID#:________________ GROUP #:________ PLAN #:________

AUTHORIZATION FOR CARE OF MINOR

I hereby authorize this office and its doctor(s) to administer care as they so deem necessary to my child (upon approval of parent or guardian).

SIGNED:________________________ WITNESSED________________ DATE:______ /______ /______

I realize that I am responsible for all fees charged by this office and I agree to pay for all services provided. X-rays remain the property of this office.

SIGNED:________________________ DATE: ______ /______ /______