Riverside Chiropractic Center

417 South Main Street, Seneca, IL 61360 Phone (815) 357-6858

Confidential Pediatric Patient History

Patient's Legal Name: _____ Date: _____
What name the patient would like to be used: _____
Age: _____ Date of birth: _____ # of Siblings: _____ Sex: M / F

Mother's Name: _____ Phone #: _____
Father's Name: _____ Phone #: _____
Legal Guardian : _____ Phone#: _____

Current Problems: _____
Is the child seeing any other doctors: _____
_____
When did these problems first occur? _____
What treatments have been tried? _____

Is the child currently getting any therapy?

Therapist	Reason for therapy	Frequency of therapy	How long
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Medication	Dosage	Reason for taking	How long taken	Prescribing Doctor
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Birth Weight: _____ Birth Length: _____
Present Weight: _____ Present Length: _____
Was the birth : ____Normal Vaginal ___Vacuum Extraction ___Breech
____Forceps ___C-section ___Home birth

Birthing Center / Hospital _____ City, State _____
OB/Midwife _____City, State _____
Pediatrician/Family MD _____ City, State_____

Pregnancy Problems _____
Labor/Delivery Problems _____
APGAR Score: Original _____ After 5 minutes _____
Was there present at birth : ____ Meconium ____ Cyanosis ____ Jaundice (yellow)
Congenital Defects/Anomalies:_____ Genetic Syndromes _____
Has this child been treated for an emergency? ___No ___Yes
Why?_____
Surgeries _____
Accidents _____
Allergies _____

Riverside Chiropractic Center

417 South Main Street, Seneca, IL 61360 Phone (815) 357-6858

Patient Name : _____ Date: _____

Vaccinations Dates (Our doctors believe it is your right to choose to vaccinate or not vaccinate. Please put N/A if you have chosen not to have this child vaccinated.)

Hepatitis B _____	OPV (oral polio) _____
DTaP _____	IPV (injected polio) _____
MMR _____	Pneumococcal Conjugate _____
VAR (chicken Pox) ____	HIB (H. Influenzae b) _____
Hepatitis A _____	Seasonal Flu _____

How long was the patient breast-fed? _____ Any feeding difficulties? _____
How long was the patient formula fed? _____ What type of formula? _____
What is the current diet? _____

Does the child consume products containing the following chemicals regularly (>1X/week)?

___Aspartame/ NutraSweet/ Splenda ___Sugar/ Fructose/ High Fructose Corn Syrup
___ Food Colorings/ Dyes ___MSG or any sodium glutamate derivative
___Hydrogenated oils ___Processed foods
___Preservatives ___Caffeine

How many serving does the child have of the of these foods daily?

Dairy____ Soy____ Grains____ Fruits____ Veggies____ Meats/Proteins____

Has your child ever suffered from any of these conditions? Please check all that apply

__ADD/ADHD	__Chicken Pox	__Measles
__Anemia	__Diabetes	__Muscle jerking/spasms
__Arm problems	__Diarrhea	__Neck Problems
__ Arthritis	__Digestion problems	__Neuritis
__Asthma	__Dizziness	__Orthopedic Problems
__Backache	__Fainting	__Paralysis
__Bed-wetting	__Growing pains	__Poor appetite
__Behavior problems	__Heart problems/murmur	__Rheumatic fever
__Broken bones	__Hyperactivity	__Hernias
__Ear infections	__Headaches	__Sinus trouble
__Colds/flu	__Hypertension	__Tuberculosis
__Constipation	__Febrile seizures	__Walking problems
__Croup	__Mumps	__Whooping cough

Please use the space below to add anything else we should know about this child.

_____
_____
_____

I certify that the information on this form is true to the best of my knowledge:

_____

Signature *Date* *Relationship to patient*