Regatta Chiropractic & Laser Center New Pediatric Patient Form

PATIENT INFORMATION

Patient Name _____ Mother's Name _____

Address _____ Mother's Occupation _____

City _____ State _____ Mother's Phone _____

Home Phone _____ Mother's Email _____

Cell Phone _____

Email _____ Father's Name _____

Sex ❑ M ❑ F Age _____ Birthday _____ Father's Occupation _____

IN CASE OF EMERGENCY, CONTACT Father's Phone _____

Name _____ Father's Email _____

Relationship _____ **Who may we thank for referring you?**

Contact Number _____ _____

HOW CAN WE HELP YOUR CHILD?

❑ Wellness Checkup ❑ Other: _____

_____

If your child is already experiencing a symptom, please describe it:

_____

_____

_____

_____

Has your child been treated on an emergency basis? ❑ Yes ❑ No

Please describe: _____

_____

PREGNANCY HISTORY

Did you experience any complications during your pregnancy? (check all that apply)

❑ Back/Other Pain ❑ Gestational Diabetes ❑ Pre/Eclampsia ❑ Strep B ❑ Nausea/Vomiting

❑ Pre-Term ❑ Fatigue ❑ Swelling ❑ Other (please describe) _____

_____

BIRTH HISTORY

Type of birth (check all that apply):

❑ Hospital ❑ Birth Center ❑ Home ❑ Normal / Vaginal ❑ Breech

❑ Cesarean ❑ Scheduled/Induced ❑ Epidural

Problems during labor / delivery? _____

_____

❑ Antibiotics ❑ Congenital Anomalies ❑ Failure to Thrive ❑ Jaundice ❑ Meconium

❑ Respiratory Distress ❑ Extended Hospitalization ❑ Other _____

GROWTH & DEVELOPMENT

Infant feeding: ❑ Breast ❑ Bottle ❑ Formula

Number of hours of sleep each night:_____ Quality of sleep: _____

At what age did the child:

Respond to sound: _____ Crawl: _____ Hold head up: _____

Stand: _____ Sit unsupported: _____ Walk unsupported: _____

CHILDHOOD DISEASES, ILLNESSES & VACCINATIONS

Has your child had (check all that apply)?:

❑ Chicken Pox ❑ Measles ❑ Robiola

❑ Mumps ❑ Rubella ❑ Pertussis/Whooping Cough

Has your child ever suffered from (check all that apply)?:

❑ Allergies ❑ Broken Bones ❑ Digestive Issues (constipation/diarrhea) ❑ Hypertension ❑ Orthopedic Problems

❑ Anemia ❑ Chronic Ear Aches ❑ Juvenile / Rheumatoid Arthritis ❑ Paralysis

❑ Arm Problems ❑ Colds/Flu ❑ Dizziness ❑ Poor Appetite

❑ Asthma ❑ Colic ❑ Fainting ❑ Joint Problems ❑ Ruptures/Hernias

❑ Back Aches ❑ Convulsions/Seizures ❑ Headaches ❑ Leg Problems ❑ Sinus Trouble

❑ Bed Wetting ❑ Delayed Speech ❑ Heart Trouble ❑ Neck Problems ❑ Tuberculosis

❑ Behavioral Problems ❑ Diabetes ❑ Hyperactivity ❑ Neuritis ❑ Walking Problems

Have you vaccinated your child?

❑ No ❑ Yes ❑ As Scheduled ❑ Delayed Schedule

ALLERIES, MEDICATIONS, SURGERIES & FAMILY HISTORY

ALLERGIES (list)

_____

_____

MEDICATIONS (list)

_____

_____

SURGERIES (list)

_____

_____

FAMILY HISTORY (list)

_____

_____

SIBLINGS

How many children do you have?_____ Number of pregnancies: _____

Children's Ages:_____ Are you currently pregnant? ❑ No ❑ Yes, I'm due: _____

Children's health concerns:_____ Health concerns regarding this pregnancy? _____

_____ _____

Authorization for Care of Minor

I hereby authorize this clinic and its doctor(s) to administer care as they so deem necessary to my son/daughter/ward.

Signed: _____ Witnessed: _____ Date: _____

Acknowledgement of Privacy Practice
** You May Refuse to Sign This Acknowledgement***

I, _____, have received a copy of this office's Privacy Policy.
Name of Patient

_____ _____
Signature of Patient/Parent/Guardian Date

Authorization to Release/Discuss Information

I, _____, being of legal age, give Shawna Hogan, D.C. authorization to release and discuss my health and dental information with the person/persons listed below.

_____ Parents Name(s) _____ Home # _____ Cell # _____ Work # _____

_____ Spouse Name _____ Home # _____ Cell # _____ Work # _____

_____ Other Name(s) _____ Home # _____ Cell # _____ Work # _____

This authorization will stay in effect unless I request that it be changed.

_____ _____
Signature Date

REGATTA
CHIROPRACTIC AND LASER CENTER