# PEDIATRIC PATIENT INTRODUCTION

**PLEASE PRINT**

CHILD'S (FULL) NAME:________________________________________ DATE:______________

BIRTH DATE:_____________________________GENDER: **M / F** AGE:___________(Months)

*MOTHER'S NAME*:____________________________________ *FATHER'S NAME*:______________________________________

ADDRESS:______________________________________________________________________ POSTCODE:_____________

TEL (H)_______________________ *MUM* (W)___________________________(M)______________________________

*DAD* (W)___________________________(M)______________________________

EMAIL:_____________________________________________________________________________________________

BIRTH WEIGHT:__________CURRENT WEIGHT: __________BIRTH LENGTH: __________CURRENT LENGTH: ____________

No OF SIBLINGS:_________TYPE OF BIRTH: **O** NORMAL VAGINAL **O** ASSISTED **O** BREECH **O** CAESAREAN

**O** HOME **O** BIRTHING CENTRE **O** HOSPITAL **O** OTHER_____________________________

PROBLEMS DURING PREGNANCY:_________________________________________________________________________

___________________________________________________________________________________________________

PROBLEMS DURING DELIVERY:__________________________________________________________________________

___________________________________________________________________________________________________

INFANT FEEDING: **O** BREAST **O** BOTTLE______________________ **O** FORMULAE_______________________

No OF HOURS SLEEP PER NIGHT:__________ QUALITY OF SLEEP: **O** GOOD **O** FAIR **O** POOR

PEDIATRICIAN/FAMILY MD:____________________________________________________________________________

IMMUNISATION HISTORY:______________________________________________________________________________

PURPOSE FOR THIS APPOINTMENT:_______________________________________________________________________

HAS YOUR CHILD BEEN TREATED ON AN EMERGENCY BASIS, IF SO, PLEASE DESCRIBE:__________________________

___________________________________________________________________________________________________

___________________________________________________________________________________________________

DESCRIBE ANY CONCERNS YOU MIGHT HAVE ABOUT YOUR CHILD'S DEVELOPMENTAL MILESTONES:____________________

___________________________________________________________________________________________________

___________________________________________________________________________________________________

HAS THE CHILD SUFFERED FROM: (please tick)

| | | | |
|---|---|---|---|
| DIABETES | BEHAVIOURAL PROBLEMS | BROKEN BONES | CHRONIC EARACHES |
| DIGESTIVE DISORDERS | BED WETTING | SPINAL PAIN | SINUS TROUBLE |
| RUPTURES/HERNIAS | HYPERACTIVITY | JOINT PROBLEMS | GROWING PAINS' |
| POOR APETITE | HEADACHES | LEG PROBLEMS | ASTHMA |
| CONVULSIONS | DIZZINESS | NECK PROBLEMS | ALLERGIES |
| | FAINTING | ORTHOPEDIC PROBLEMS | ARTHRITIS |

SURGERY:___________________________________________________________________________________________

MEDICATIONS:_______________________________________________________________________________________

ACCIDENTS:_________________________________________________________________________________________

FAMILY HISTORY:____________________________________________________________________________________

**CONSENT ON BEHALF OF A MINOR:** I CONFIRM THAT THE DETAILS ABOVE ARE CORRECT AND GIVE CONSENT TO AN EXAMINATION BY THE CHIROPRACTOR. I HEREBY AUTHORISE THIS CLINIC AND ITS DOCTOR(S) TO ADMINISTER CARE AS THEY SO DEEM NECESSARY FOR MY SON / DAUGHTER / WARD. I REALISE THAT I AM RESPONSIBLE FOR ALL FEES CHARGED BY THIS CLINIC AND THAT I WILL PAY FOR ANY SERVICES AS THEY ARE PERFORMED.

SIGNATURE:_____________________________________________ DATE:______________________________