HELLENBRAND
RABIDEAUX
CHIROPRACTIC

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PEDIATRIC PATEINT HISTORY

Personal Information

CHILD'S NAME: D.O.B.: SEX: AGE: DATE:

MOTHER'S NAME: FATHER'SNAME

ADDRESS:

CITY.STATE/ZIP:

PHONE #: MOTHER'S CELL #: FATHER'S CELL #:

EMAIL ADDRESS:

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

Current Health Information

PURP OSE OF THIS APPOINTMENT:

Have you seen anyone else for this condition? □ Chiropractor □ Medical Doctor

Name: Date:

What was done?

What was the diagnosis?

BIRTH WEIGHT: CURRENT WEIGHT:

TYPE OF BIRTH: □NORMAL □VAGINAL □FORCEPS □BREECH □CESAREAN
□HOME □BIRTHING CENTER: □HOSPITAL:

PREGNANCY HISTORY (INCLUDE ANY PROBLEMS DURING PREGNANCY):

BIRTH HISTORY (INCLUDE ANY PROBLEMS DURING LABOR/DELIVERY):

WAS THERE PRESENCE AT BIRTH OF: □JAUNDICE (YELLOW) □CYANOSIS (BLUE)

APGAR SCORES: COGENITAL ANOMALIES/DEFECTS:

INFANT FEEDING: □BREAST □BOTTLE □FORMULA

NO. OF HOURS OF SLEEP PER NIGHT: QUALITY OF SLEEP: □GOOD □FAIR □POOR

OBSTETRCIAN/MIDWIFE: _____ LOCATED AT: _____

PEDIATRICIAN/FAMILY MD: _____ LOCATED AT: _____

IMMUNIZATION HISTORY: _____

MEDICATIONS: _____

HAS YOUR CHILD BEEN TREATED ON AN EMERGENCY BASIS: _____

ACCIDENTS/TRAUMA/INJURIES: _____

SURGERY: _____

CHILDHOOD DISEASES:

□CHICKEN POX □RUBELLA
□MUMPS □RUBEOLA
□MEASLES □WHOOPING COUGH
□OTHER: _____

HAS THIS CHILD EVER SUFFERED FROM:

□ Allergies	□ Anemia	□ Asthma	□ Arm Problems
□ Arthritis	□ Backaches	□ Bed Wetting	□ Behavioral Problems
□ Broken Bones	□ Colds/Flu	□ Convulsions	□ Chronic Earaches
□ Constipation	□ Diarrhea	□ Dizziness	□ Digestive Disorders
□ Diabetes	□ Fainting	□ "Growing Pains"	□ Headaches
□ Hyperactivity	□ Hypertension	□ Heart Trouble	□ Joint Problems
□ Leg Problems	□ Neuritis	□ Neck Problems	□ Orthopedic Problems
□ Muscle Jerking	□ Paralysis	□ Poor Appetite	□ Rheumatic Fever
□ Rupture/Hernia	□ Tuberculosis	□ Sinus Trouble	□ Sugar Concentration
□ Walking Problems		□ Other: _____	

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.

I consent to a professional and complete chiropractic examination and to any radiographic examination that the doctor deems necessary. I understand that I am responsible for my bill and that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

SIGNED: _____ WITNESSED: _____ DATE: ____/____/____

Thank you for taking the time to fill out this form in its entirety and for choosing

Hellenbrand Rabideaux Chiropractic