

# CORRECTIVE CARE CHIROPRACTIC

234 Littleton Road, Unit B, Suite 1A, Westford, MA 01886  
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## Pediatric Patient Information

Child's Name \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Mother's Name \_\_\_\_\_

Father's Name \_\_\_\_\_

Address \_\_\_\_\_

City/Town \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: \_\_\_\_\_ Mother's Work Phone: \_\_\_\_\_

Father's Work Phone: \_\_\_\_\_

Birth Weight \_\_\_\_\_ Birth Length \_\_\_\_\_

Current Weight \_\_\_\_\_ Current Length/Height \_\_\_\_\_

Type of Birth:  Normal Vaginal  Forceps  Breech  Cesarean

Home  Birthing Center  Hospital

APGAR Scores: \_\_\_\_\_ Was there presence at birth of:  Jaundice (Yellow)  Cyanosis (Blue)

Congenital Anomalies/Defects: \_\_\_\_\_

Infant Feeding:  Breast  Bottle  Formula

Hours of Sleep per Night: \_\_\_\_\_ Quality of Sleep:  Good  Fair  Poor

Date of Last Visit to MD: \_\_\_\_\_ Purpose: \_\_\_\_\_

Immunization History: \_\_\_\_\_

Purpose of This Appointment: \_\_\_\_\_

Has Your Child Been Treated on an Emergency Basis?  Yes  No If yes, describe:

\_\_\_\_\_  
\_\_\_\_\_

## Authorization for Care of a Minor

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

Parent/guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_

I realize that I am responsible for all fees charged by this clinic and that I will pay for all services as they are performed. X-rays remain the property of this clinic.

Parent/guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Pediatric Case History

Any problems during pregnancy? \_\_\_\_\_

Problems during labor/delivery? \_\_\_\_\_

**Developmental History:** *At what age did your child:*

Respond to sound \_\_\_\_\_ mos      Crawl \_\_\_\_\_ mos      Stand \_\_\_\_\_ mos  
Follow an object with his/her eyes \_\_\_\_\_ mos      Hold head up \_\_\_\_\_ mos  
Sit Alone \_\_\_\_\_ mos      Walk Alone \_\_\_\_\_ mos

**Childhood Diseases:**    Chickenpox    Rubella    Mumps    Measles    Whooping Cough

Other: \_\_\_\_\_

**Has this child ever suffered from:**

- |  |   |   |  |   |
|--|---|---|--|---|
| <input type="checkbox"/> Dizziness     | <input type="checkbox"/> Diabetes         | <input type="checkbox"/> Arthritis            | <input type="checkbox"/> Neuritis            | <input type="checkbox"/> Anemia           |
| <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Bed Wetting      | <input type="checkbox"/> Fainting             | <input type="checkbox"/> Neck Problems       | <input type="checkbox"/> Joint Problems   |
| <input type="checkbox"/> Backaches     | <input type="checkbox"/> Tuberculosis     | <input type="checkbox"/> Headaches            | <input type="checkbox"/> Digestive Disorders | <input type="checkbox"/> Asthma           |
| <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Walking Problems | <input type="checkbox"/> Arm Problems         | <input type="checkbox"/> Leg Problems        | <input type="checkbox"/> Heart Trouble    |
| <input type="checkbox"/> Hypertension  | <input type="checkbox"/> Sinus Trouble    | <input type="checkbox"/> Broken Bones         | <input type="checkbox"/> Orthopedic Problems | <input type="checkbox"/> Paralysis        |
| <input type="checkbox"/> Colds/Flu     | <input type="checkbox"/> Chronic Earaches | <input type="checkbox"/> Allergies            | <input type="checkbox"/> Sugar Concentration | <input type="checkbox"/> Constipation     |
| <input type="checkbox"/> Diarrhea      | <input type="checkbox"/> Muscle Jerking   | <input type="checkbox"/> Growing Pains        | <input type="checkbox"/> Behavioral Problems | <input type="checkbox"/> Ruptures/Hernias |
|  | <input type="checkbox"/> Rheumatic Fever  | <input type="checkbox"/> Convulsions/Seizures |  |   |

Present History: \_\_\_\_\_

Has your child had any significant injuries? (fractures, stitches, falls, sports-related, etc.) Please list dates, injury and treatment: \_\_\_\_\_

Is your child on any medications? Please list, indicating dose/frequency: \_\_\_\_\_

Accidents/Falls: \_\_\_\_\_