



11707 Bowman Green Dr.
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PEDIATRIC REGISTRATION FORM

BIRTH- 12 YEARS

CHILD'S INFORMATION

NAME:	
ADDRESS:	
CITY:	STATE: POSTAL CODE:
HOME PHONE:	
GENDER:	BIRTHDAY: (MM,DD,YYYY)
PARENTS/GUARDIAN:	
HOW DID YOU HER ABOUT US? REFERRED BY:	

___ PHONEBOOK ___ FLYER ___ INTERNET OTHER: _____	
REASON FOR VISITING OUR OFFICE? _____	

BIRTH & DELIVERY

GAVE BIRTH AT _____ WKS	APGAR _____	
BIRTH WEIGHT: _____	LENGTH OF LABOUR: _____	
Vaginal birth/ C-section (reason) _____	Home/ Hospital	
List people used for labour support: _____		

Circle all intervention that apply to this birth:		
Induction of labour	Oxytocin/Ptocin	Vacuum
Epidural	Forceps	Episiotomy
Fetal Monitoring	doctor pulled baby out	
Other: _____		
COMPLICATIONS?		
Mother: _____		
BABY: _____		

ABOUT THE PARENT/GUARDIAN

PARENT/GUARDIAN NAME:	
ADDRESS: SAME AS ABOVE _____	
CITY:	STATE: POSTAL CODE:
HOME PHONE:	
EMAIL:	
EMPLOYER NAME:	
EMPLOYER ADDRESS:	
WORK PHONE:	POSITION/TITLE:
PERFERED FORM OF CONTACT:	

FEEDING & ELIMINATION

Breastfed	How long? _____
	Difficulties? _____
Formula	Type? _____ Length of time on Formula? _____
FEEDING PROBLEMS? _____	
Age:	Weaned? _____ Cow's Milk? _____ Solids? _____
Allergies to food? _____	
Toilet trained: age _____	Difficulties with toilet training: _____

PRENATAL HISTORY

TOTAL WEIGHT GAIN: _____ LBS
PLEASE CHECK ALL THAT APPLY (PHYSICAL/CHEMICAL/EMOTIONAL STRESSORS):
___ NAUSEA/VOMITING ___ HYPERTENSION ___ DIABETES
___ BED REST ___ NOT FIRST PREGNANCY
___ VITAMINS/HERBS ___ CONSUMED ALCOHOL/TOBACCO
___ NUMBER OF ULTRASOUNDS ___ INVASIVE PROCEDURES (IE: amniocentesis)
___ MEDICATION(S) ___ STRESS

I hereby authorize and consent to the chiropractic consultation, examination and other diagnostic testing to determine if my child should be under chiropractic care. I have read and agree that all information provided is accurate to the best of my knowledge. I also agree that it is my responsibility to inform the doctor if any information changes.

Parent or Guardian Signature: _____
Witness: _____

GROWTH & DEVELOPMENT:

Was the infant alert & responsive within 12 hours of the delivery? YES NO If no, explain: _____

At what age did the child:

Respond to sound? _____ Follow an object? _____ Hold up head? _____ Vocalize? _____

Sit Alone? _____ Teethe? _____ Crawl? _____ Walk? _____

Are you concerned about sleep patterns? _____

Describe any health problems that exist on the mother's side of the family? (Cancer, Diabetes etc.) _____

The father's side? _____

Do the child's siblings have any health problems? _____

STRESSORS

(The following information is very important because many of the problems that chiropractors work with are caused by stressors)

CHEMICAL:

Did your child receive vaccinations? Y N If Yes, which ones? _____

Did your child react to any vaccinations? Y N

Has your child had antibiotics? Y N If Yes, how many courses has the child had so far & why? _____

Any pets at home? Y N Any smokers at home? Y N If Yes, how much? _____

PSYCHOLOGICAL STRESSORS:

Any difficulties with lactation? Y N Any problems bonding with child? Y N Does your child seem normal to you? Y N

Does the child have any behavior problems? Y N If Yes, what? _____

Does your child have difficulties sleeping (night terrors, sleepwalking, bedwetting)? Y N If Yes, specify: _____

Did your child go to daycare? Y N From what age? _____ Average number of hours of TV/Computer per week? _____ hrs.

TRAUMATIC STRESSORS:

Any evidence of trauma during birth? Bruises Odd shaped head stuck in birth canal Fast and/or excessively long birth

Respiratory depression Cord around neck Other _____

Any fall/accidents during pregnancy? Y N has the child had any major falls since birth? Y N If Yes, did the child need stitches or cause a fracture? Please describe: _____

Any hospitalization? Y N Please explain: _____

Does your child play sports? Y N If Yes, number of hours per week? _____ Age child began _____

Weight of school backpack? _____ Approx. hours spent at play per week? _____



As a baby/toddler (birth-4yrs), did any of the following occur? (Circle all that apply)

Fall from a changing table	Frequent crying spells	Tumble down stairs
Frequent fevers	Frequent bedwetting	Fall out of crib
Frequent bouts of diarrhea	Constipation	Involvement in car accident
Sleeping problems	Play in a jolly jumper	Fall off playground equipment
Frequent colds	Frequent ear infections	Colic
Tonsillitis	Did not gain weight	Reaction to vaccination(s)

Other: _____

Please explain the above: _____

As a young child, (5-12 yrs), did any of the following occur? (Circle all that apply)

Fall from tree	Bedwetting	Fall off a bicycle
Hyperactivity	Autism	Fall off playground equipment
Learning disabilities	Car accident	Sport related accident/injury
Asthma	Allergies	Stomach pains
Leg/knee pain	Scoliosis	Other:

Please explain the above: _____

As a child or adolescent, has your child experienced any of the following?

Headaches	Numbness in arms/hands	Foot/ankle/knee pain
Dizziness	Arm/wrist pains	Tingling in arms/legs
ringing in ears	Sleeping problems	Neck/back pains
Asthma	Allergies	Shoulder pains
Hyperactivity	Stomach problems	Growing pains
Fatigue	Weight gain/loss	Other:

Please explain the above: _____

Tell us about any vaccinations your child has received:

_____ Full Recommended Schedule

_____ Modified Schedule

_____ No vaccinations have been given

_____ Additional Vaccines: _____