Pappas Chiropractic **Anthony Pappas, D.C., P.C.**

Pediatric Form

Child's Name:______________________________________ Today's Date:____________________

Please Print First Middle Last

Address:____________________________________ Social Security #:______________________

City:________________ State:_____ Zip:_________ Date of Birth:_________________ Age:_____

Home Phone:_________________________________ □ Male □ Female

Parent # 1 Name:_____________________________ Work/Cell #:__________________________

First Middle Last

Parent # 2 Name:_____________________________ Work/Cell #:__________________________

First Middle Last

Insured Parent's SSN #:__________________________ Insured Parent's Date of Birth:______________

Parent's E-mail Address:____

BIRTH INFORMATION

Type of birth: □ Vaginal □ Forceps □ Breech □ Cesarean □ Home □ Birthing Center _______ □ Hospital __________

Birth Weight:__________ Birth Length:__________ Apgar Scores:__________

At birth: Jaundice (yellow) □ Yes □ No Cyanosis (blue) □ Yes □ No

Medication taken during pregnancy? □ Yes □ No ________________________________ Epidural: □ Yes □ No

Please list any problems during pregnancy and/or labor:____

____

____

Congenital Anomalies/Defects:____

Infant Feeding: □ Breast □ Bottle □ Formula Other food or drink information:_______________________

____

#of hours child sleeps daily:__________ Quality of sleep: □ Good □ Fair □ Poor

Explain:____

# of siblings:_______ Please list names and ages:____

MEDICAL INFORMATION

Pediatrician and/or Family MD Name:___________________________ Location:____________________

Date of last visit to doctor:____________ Purpose of that visit:_______________________________________

____

Immunization History:____

____

Has your child ever been treated on an emergency basis? □ Yes □ No Please describe:_____________________

____

HEALTH INFORMATION

Reason for visit today:____

____

____

Condition started on:____

Is condition getting progressively worse? □ Yes □ No Please describe:______________________

Other doctors seen for this condition:______________________________

Any home remedies?____

DEVELOPMENTAL HISTORY- at what age did the child:	CHILDHOOD DISEASES- age of the child when occurred:
Respond to sound: __________	Chicken pox: __________
Crawl: __________	Rubella: __________
Follow an object with their eyes: __________	Rubeola: __________
Hold head up: __________	Whooping cough: __________
Stand: __________	Mumps: __________
Sit alone: __________	Measles: __________
Walk alone: __________	Other: __________

Has this child ever suffered from (please check all that apply):

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

□ Any other Problem: ____

Present Health History or Additional Information: ______________________________

____

Has the child had any surgeries? □ Yes □ No What and When? ______________________

____

Accidents: ____

MEDICATIONS: ______________________ VITAMINS: ______________________

______________________ ______________________

______________________ ______________________

Family Health History

	Heart Disease	Arthritis	Cancer	Diabetes	Other ________
Father's Side	❐	❐	❐	❐	❐
Mother's Side	❐	❐	❐	❐	❐

Upon the completion of your first visit, you will receive a Chiropractic Report to discuss the different types of Active Life Plans that are available to you. Chiropractic Active Life Plans are designed to help get you feeling better quickly and to help you and your family be as healthy as possible. Please review the explanations of the Chiropractic Active Life Plans prior to your Chiropractic Report appointment so you can choose the level of participation that supports you in reaching all of your health goals.

______________________ ______________________ ______________________

Parent's Signature Relationship to Patient Date