

PEDIATRIC HISTORY

Please Fill Out Completely

PATIENT NAME: _____ BIRTH DATE ____/____/____ AGE ____ SEX M / F

S.S.# ____ - ____ - ____ HEIGHT _____ WEIGHT _____

NAME OF PARENTS / GUARDIANS _____

ADDRESS: _____ CITY _____ STATE ____ ZIP _____

HOME PHONE: _____ WORK PHONE: _____

REASON FOR CONTACTING US? _____

OTHER DOCTORS SEEN FOR THIS CONDITION? Y / N NAME: _____

PHONE NUMBER: _____ PRIOR TREATMENTS _____

OTHER HEALTH PROBLEMS/ CONCERNS: _____

HAS YOUR CHILD BEEN INVOLVED IN ANY HIGH IMPACT / CONTACT TYPE SPORTS (SOCCER, FOOTBALL, GYMANASTICS, BASEBALL, CHEER LEADING, MARTIAL ARTS, ETC.)? Y / N Injuries: _____

HAS YOUR CHILD EVER BEEN INVOLVED IN A CAR ACCIDENT? Y / N LIST DATES / INJURIES: _____

HAS YOUR CHILD EVER HAD SURGERY OR BEEN HOSPITALIZED? Y / N LIST: _____

ACCORDING TO THE NATIONAL SAFETY COUNCIL, APPROXIMATELY 50% OF CHILDREN HAVE HAD A FALL FROM A HIGH PLACE DURING THEIR FIRST YEAR OF LIFE (BED, CHANGING TABLE, STAIRS, ETC.) WAS THIS THE CASE WITH YOUR CHILD? Y / N LIST: _____

NAME OF OBSTETRICIAN / MIDWIFE: _____ PHONE: _____

COMPLICATIONS DURING PREGNANCY _____ DELIVERY _____

OF ULTRASOUNDS DURING PREGNANCY? _____ MEDICATIONS DURING PREGNANCY / DELIVERY? Y / N

LIST: _____
LOCATION OF BIRTH: HOSPITAL BIRTHING CENTER HOME OTHER: _____

PTOCIN INDUCED LABOR Y / N LABOR TIME _____ BIRTH INTERVENTION: FORCEPS VACUUM EXTRACTION C-SECTION

APGAR SCORE _____ BIRTH WEIGHT ____ LB ____ OZ BIRTH LENGTH _____

FEEDING HISTORY

BREAST FED: Y / N HOW LONG: _____ DIFFICULT NURSING (TURNING HEAD): RIGHT / LEFT

FORMULA FED: Y / N HOW LONG: _____ INTRODUCED SOLIDS AT: _____ MONTHS COWS MILK AT _____ MONTHS

ALLERGIES OR INTOLERANCE: Y / N LIST: _____

DOES YOUR CHILD HAVE / HAD ANY OF THESE PROBLEMS? (Please circle)

RECURRING EAR INFECTIONS / TONSILLITIS / STREP THROAT / BED WETTING / DIGESTIVE DISORDERS / PERSISTANT DIARRHEA or CONSTIPATION / HYPERACTIVITY / ADD/ADHD / ASTHMA / BLOOD DISORDERS / HEADACHES / SEIZURES
GROWING PAINS / UPPER RESPIRATORY INFECTIONS / BEHAVIORAL PROBLEMS OTHER: _____

VACCINATION HISTORY FULL SERIES or HALF / PARTIAL SERIES

HAS YOUR CHILD HAD ANY CHILDHOOD DISEASES:

CHICKEN POX Y / N AGE ____ MEASLES Y / N AGE ____ MUMPS Y / N AGE ____
RUBELLA Y / N AGE ____ WHOOPING COUGH Y / N AGE ____ HEPATITIS Y / N TYPE ____ AGE ____
OTHER: _____

DID YOUR CHILD SHOW ANY OF THE SIGNS OF VACCINE REACTION (THESE MAY OCCUR WITHIN HOURS TO SEVERAL DAYS AFTER VACCINATION) NO / YES (pleases circle): UNEXPLAINED ALERGIES, HIVES OR RASH, HIGH FEVER, VOMITING, SWOLLEN LIMBS, SWOLLEN SHOT SITE, PROBLEMS BREATHING, HIGH PITCH SCREAM OR CRY, SEIZURES OR CONVULSIONS, OTHER: _____

To the best of my knowledge, the information provided is accurate and correct. I authorize the doctor to perform an examination (including x-rays & diagnostics, if needed) for treatment purposes. **I understand that I am responsible for all charges relating to care provided in this office. I authorize assignment of my insurance rights and benefits, directly to the provider for services rendered.**

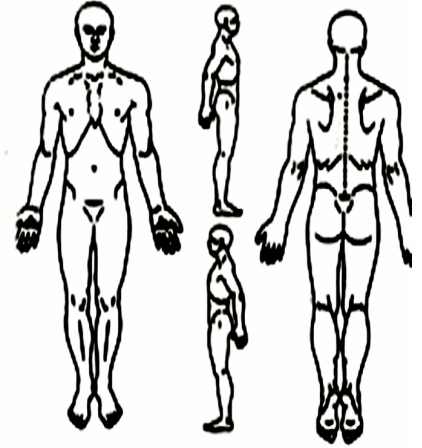
Patient Signature

Parent / Guardian Signature (minors)

Date

HISTORY OF PRESENT ILLNESS

Mechanism: _____
 Onset: _____
 Location: _____
 Describe: _____ VAS _____ /10
 Frequency: _____
 Palliative: _____
 Provocative: _____
 Timing: _____
 Radiation: _____
 TX: _____
 Notes: _____



EXAMINATION

<p><u>POSTURE</u> HEAD TILT R / L HEAD SHIFT R / L HEAD ROTATION R / L HEAD A / P HIGH SHOULDER R / L HIGH HIP R / L WEIGHT R ____ L ____ <u>CHIRO</u> SUPINE SHORT LEG R / L DEREFIELD LEG R / L NEG SACRAL LEG SAR / SAL <u>PALPATION</u> PAIN / TENDER C T L P EDEMA C T L P SPASM C T L P <u>CERVICAL ROM</u> FLEX ____ EXT ____ RLF ____ LLF ____ RROT ____ LROT ____ <u>LUMBAR ROM</u> FLEX ____ EXT ____ RLF ____ LLF ____ <u>EXTREMITY</u> _____ _____ <p align="center"><u>OTHER</u></p> _____ _____ _____ _____</p>	<p><u>ORTHO/NEURO</u> FORAMINAL COMPRESSION R / L / EXT SHOULDER DEPRESSOR R / L KEMPS R / L ELY R / L SLR R / L TRENDELENGURG R / L BODY SQUAT _____ <u>REFLEXES</u> R / L</p>																								
	<table style="width:100%; border-collapse: collapse;"> <tr> <td>BICEPS</td> <td>/</td> </tr> <tr> <td>BRACHIORADIALIS</td> <td>/</td> </tr> <tr> <td>TRICEP</td> <td>/</td> </tr> <tr> <td>PATELLAR</td> <td>/</td> </tr> <tr> <td>ACHILLES</td> <td>/</td> </tr> </table> <p><u>MUSCLE TEST</u></p> <table style="width:100%; border-collapse: collapse;"> <tr> <td>SH ABD</td> <td>5 4 3 2 1</td> </tr> <tr> <td>BICEPS</td> <td>5 4 3 2 1</td> </tr> <tr> <td>WRIST</td> <td>5 4 3 2 1</td> </tr> <tr> <td>INTEROSSEUS</td> <td>5 4 3 2 1</td> </tr> <tr> <td>HIP FLEX</td> <td>5 4 3 2 1</td> </tr> <tr> <td>KNEE EXT</td> <td>5 4 3 2 1</td> </tr> <tr> <td>KNEE FLEX</td> <td>5 4 3 2 1</td> </tr> </table> <p><u>SENSATION</u> PINWHEEL UPPER _____ PINWHEEL LOWER _____ VIBRATION UPPER _____ VIBRATION LOWER _____</p> <p align="center"><u>INFANTS (Reflexes)</u></p> Plantar (Birth - 2yrs) Babinski Sign + / - Palmar Grasp (Birth - 3m) _____ Plantar Grasp (Birth - 8m) _____ Moro (Birth - 6m) _____ Placing (4d - Varies) _____ Stepping (Birth - Walking) _____ Fencing (2m - Rollover) _____	BICEPS	/	BRACHIORADIALIS	/	TRICEP	/	PATELLAR	/	ACHILLES	/	SH ABD	5 4 3 2 1	BICEPS	5 4 3 2 1	WRIST	5 4 3 2 1	INTEROSSEUS	5 4 3 2 1	HIP FLEX	5 4 3 2 1	KNEE EXT	5 4 3 2 1	KNEE FLEX	5 4 3 2 1
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RX: _____

Dr Signature: _____ **Date:** _____