Pediatric Application for Care

Please take a moment to fill out this form and sign the bottom.
Thanks! We will take GREAT care of your family here!

Child's Name____ Mother's Name____________________________________
Last First M Last First M
Date of Birth____/_____/____ Age:_____ Father's Name______________________________________
Last First M
Sex (Circle): **Male** or **Female** SSN:___________________ Birth Weight: ___________ Current Weight:__________
Address____ City_________________ State_____Zip___________
Home Phone_________________ Cell Number___________________Email____
How did you hear about our office?_______________________
Type of Birth: Normal/Vaginal_____ Forceps______ Breech______ Home______ Hospital______ Cesarean______
Describe any problems during pregnancy:____
____
Describe any problems with labor/delivery?____
____
APGAR Scores (1min/5min) _______/_________Jaundice? (yellow) **Yes** or **No** Cyanosis? (blue) **Yes** or **No**
Congenital Anomalies/Defects: ____
Infant Feeding (please indicate length of time spent as primary source of nutrition): Breast_______ Formula______
Quality of Sleep: Good Fair Poor Hours of Sleep per Night (Average):________
Immunization History____
Any childhood diseases?____
Purpose of Last Visit to MD____Date______________
Purpose of This Appointment____

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

Dizziness	Behavioral problems	Arm problems	'Growing pains'
Diabetes	Backaches	Ruptures/hernias	Stomachaches
Anemia	Headaches	Blood disorders	Chronic earaches
Poor appetite	Digestive disorders	Heart troubles	Cold/Flu
Bed wetting	Rheumatic fever	Diabetes/hypoglycemia	Allergies
Fainting	Hyperactivity	Paralysis	Constipation
Neck problems	Seizures	Broken bones	Diarrhea
Joint problems	Walking problems	Leg problems	Asthma

Other:____
Surgery:____
Medications:____
Accidents:____
Family History:____
Has your child ever been treated on emergency basis: **Yes** or **No** If yes, why?__________________________
Do you have any type of health insurance? **Yes** or **No** If yes, Company____________________ID #________________
**Please provide us with your insurance card so we may photocopy.

Consent to Treat Minor

I hereby authorize Dr. Pamela Woodward and whomever she may designate as his assistants to administer treatment, as she as deems necessary to my child_____________________________________.

Dated__________________ day of_______________________20_________.
Signed____.

I agree to assume responsibility for any charges created by the chiropractic care, and give consent for my child to be examined and/or treated by Dr. Woodward and her staff.

Parental Signature____
Date________________________________