FIRST STEP CHIROPRACTIC

Pediatric Application for Care

Child's Name_____ Parent Name_____
Last First M Last First M
Date of Birth____/_____/____ Age:_____ Parent 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 (check all that apply): Vaginal___ Forceps or vacuum____ 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)

Allergies	Chronic earaches	Food Allergy/Sensitivity	Latch Issues
Altered Gait	Cold/Flu	'Growing pains'	Leg problems
Anemia	Colic	Headaches	Neck problems
Arm problems	Constipation	Heart defects/anomolies	Paralysis
Asthma	Diabetes/hypoglycemia	Hernia	Poor Appetite
Backaches	Diarrhea	Hip dysplasia	Reflux
Bed wetting	Dizziness	Hyperactivity	Seizures
Behavioral Concerns	Fainting	Joint problems	Stomachaches

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 her assistants to administer treatment, as she as deems necessary to my child_____.

Signed_____ Date_____

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_____