MEEKER CHIROPRACTIC
4229 Northern Pike | Monroeville, PA 15146
Telephone: 412-856-1051

NEW PEDIATRIC PATIENT FORM

Patient Name: _____ SSN#: _____

Address: _____ City: _____

State: _____ Zip Code: _____Telephone: _____

Birth Date: _____/_____/_____ Sex: _____ Weight: _____ Height: _____

Name(s) of Parent(s) / Guardian(s): _____

Purpose for Contacting Us?_ _____

Other Doctors seen for this condition? ___YES ___ NO Doctors Names and Prior Treatment: _____

_____

Other Health Problems? _____

Check any of the following conditions your child has suffered from during the past six (6) months:

___ Ear Infections	___ Scoliosis	___ Seizures	___ Chronic Colds	___ Headaches
___ Asthma/Allergies	___ Digestive Problems	___ ADHD	___ Recurring Fevers	___ Growing/Back Pains
___ Colic	___ Bed Wetting	___ Car Accident	___ Temper Tantrums	___ Other _____

Family History: _____

Previous Chiropractor: _____ Date of Last Visit: _____/_____/_____

Reason: _____

Name of Pediatrician: _____ Date of Last Visit: _____/_____/_____

Reason: _____

Are you satisfied with the care your child received there? ____YES ____ NO

Number of doses of Antibiotics your child has taken:

During the past six (6) months: _____ Total during his/her lifetime: _____

Number of doses of other Prescription medications your child has taken:

During the past six (6) months: _____ Total during his/her lifetime: _____

Please list medications: _____

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Vaccination History: _____

PRENATAL HISTORY

Name of Obstetrician/Midwife: _____

Complications during pregnancy: ___ YES ___ NO List: _____

Ultrasounds during pregnancy: ___ YES ___ NO How many: _____

Medications during pregnancy: ___ YES ___ NO List: _____

Cigarette / Alcohol use during pregnancy: ___ YES ___ NO

Location of birth: Hospital _____ Birthing Center _____ Home

Birth Intervention: _____Forceps _____ Vacuum Extraction _____ Cesarean Section (Emergency or Planned)

Complications during delivery: ___ YES ___ NO List: _____

Generic disorders or disabilities: ___ YES ___ NO List: _____

Birth Weight: _____ Birth Length: _____ APGAR Scores: _____, _____

FEEDING HISTORY

Breast Fed: ___ YES ___ NO How long: _____

Formula Fed: ___ YES ___ NO How long: _____ Type: _____

Introduced to solids at: _____ months. Cow's milk at: _____ months

Food/ Juice allergies or intolerances: ___ YES ___ NO List: _____

DEVELOPMENT HISTORY

During the following times your child's spine is most vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of verbal subluxation (spine nerve interference). At what age was your child able to:

___ Respond to sound ___ Hold head up ___ Cross Crawl ___ Walk alone
___ Respond to visual stimuli ___ Sit up ___ Stand along

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e., a bed, changing table, down stairs, etc.). Was this the case with your child? ___ YES ___ NO

Is / has your child been involved in any high impact or contact type sports (i.e., Soccer, Football, Gymnastics, Baseball, Cheerleading, Martial Arts, etc.)? ___ YES ___ NO List: _____

_____

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Has your child ever been involved in a car accident? ___ YES __ NO List: _____

_____

Has your child been seen on an Emergency basis? ___ YES ___ NO List: _____

Other Traumas not described above: ___ YES ___ NO List: _____

Prior surgery: ___ YES ___ NO List: _____

Menarche (first menstrual period): ___ YES ___ NO Age: _____

CHILDHOOD DISEASES

Chicken Pox	___ YES ___ NO	At what age? ____	Mumps	___ YES ___ NO	At what age? ____
Rubella	___ YES ___ NO	At what age? ____	Whooping Cough	___ YES ___ NO	At what age? ____
Measles	___ YES ___ NO	At what age? ____	Other	___ YES ___ NO	At what age? ____

_____

WE ARE HERE TO SERVE YOU AND ENCOURAGE YOU TO ASK QUESTIONS.
YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR RESULTS.

AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize this office and its Doctor(s) to administer care to my Son/Daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Name of Insurance Co: _____ Policy #: _____

Signed: _____ Date: _____/_____/ _____