Optimal Wellness Chiropractic Center, P.C.

5755 North Point Parkway, Suite 48 ~ Alpharetta, GA 30022 ~ 678.893.0060

Pediatric Registration and History Form

Date_________________

Last name___________________________ First name _________________________ MI _____

Parent/Guardian's name ____

Address ____

City_________________________________ State _____________ Zip _______________

Parent/Guardian's Phone (H) ______________________ (C) ______________________

Patient's Date of Birth _______________ Social Security No. _________________

IN CASE OF EMERGENCY, CONTACT:

Name _________________________ Relationship ____________________ Phone ___________

Whom may we thank for referring you? ____

INSURANCE INFORMATION

Primary insured's name _______________________ Relationship ______________ DOB _________

Health Ins. Company ___________________________ Member ID# _______________________

Group # _________________________ Insurance Co. Phone # __________________________

Is the patient covered by additional insurance? ____Yes ____No

Insurance Co. _______________________ Member ID/Group #___________________________

PATIENT CONDITION

Reason for visit____

Date symptoms first appeared _________ How? ____Gradual ____Sudden_____Progressive

Have you been treated already for this condition? ___Y/N Doctor's name and type of treatment:
____

Have you ever been treated by a Doctor of Chiropractic? ____Y/N Doctor's name___________

CURRENT HEALTH AND PRENATAL HISTORY

Name of Pediatrician: ____

Date of last visit:______________ Reason: _______________________________________

Are you satisfied with the care your child has received there? Y/N

Number of doses of Antibiotics your child has taken:
During the past 6 months:________ During his/her lifetime:________

Vaccination History: ____

Previous Chiropractors seen: ____

Date of last visit ___/___/_____ Reason: ____

Name of Obstetrician/Midwife: ____

Complications during pregnancy? _____Yes _____No, List: _________________________________

Complications during delivery? _____Yes _____No, List: ___________________________________

Ultrasounds during pregnancy? _____Yes _____No, Number: ______

Medications during pregnancy? Delivery? _____Yes _____No, List: __________________________

Location of Birth: _____Hospital _____Birthing Center _____Home

Birth Interventions: _____Forceps _____Vacuum Extraction _____Cesarean Section, Emergency or Planned? _______________

Cigarette / Alcohol use during pregnancy: Y / N

Genetic Disorders or Disabilities: _____ Yes _____ No, List: ________________________________

Birth Weight: _____________ Birth Length: _____________

FEEDING HISTORY

Breastfed:___Yes___No, How Long:_______________________

Formula Fed:_____Yes_____No, How Long: __________________ Type:____________________________

Introduced Solids at: _____months, Cows milk at:_______months

Food/Juice Allergies or Intolerances: ______No______Yes. List:___________________________________

DEVELOPMENTAL 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 vertebral subluxtion (spinal never interference). At what age was your child able to:

________Respond to Sound _______Cross Crawl _______Stand Alone

_______Respond to Visual Stimuli _______Walk Alone _______Hold Head Up

_______Sit Up

According to the National Safety Council, approximately 50% of Children fall from a high place during the first year of life (i.e. Bed, Changing Table, Down Stairs, etc.) Was this the Case with your Child?
_______Yes______No

Is/Has your child been involved in any high impace or contace type sports (i.e. Soccer, Football, Gymnastics, Baseball, Cheerleading, Martial Arts, etc.)? _____Yes_____No, List:_____________________

Has your child been involved in a car accident? ___No___Yes, List:______________________________

Has your child been seen on an emergency basis___No_____Yes, List:____________________________

Other traumas not described above?___No_____Yes, List:_______________________________________

Prior Surgery:_____No______Yes, List:____

Onset of Menstruation:_____Yes_____No, Age:_________

CHILDHOOD DISEASE

Chicken Pox Y/N, Age:_____ Mumps Y/N, Age:_______

Rubella Y/N, Age:______ Whooping Cough Y/N, Age:_______

Rubeola Y/N, Age:______ Hepatitis Y/N, Age:________

Measles Y/N, Age:_______ Other Y/N, Age:__________