Pappas Chiropractic **Anthony Pappas, D.C., P.C.**

Pediatric Form

Child's Name:____ Today's Date:______________________
Please Print First Middle Last

Address:____ Social Security #:__________________________

City:___________________ State:______ Zip:___________ Date of Birth:___________________ Age:_____

Home Phone:______________________________________ □ Male □ Female

Parent # 1 Name:__________________________________ Work/Cell #:______________________________
First Middle Last

Parent # 2 Name:__________________________________ Work/Cell #:______________________________
First Middle Last

Insured Parent's SSN #:_____________________________ Insured Parent's Date of Birth:_______________

Parent's E-mail Address:____

BIRTH INFORMATION

Type of birth: □ Vaginal □ Forceps □ Breech □ Cesarean □ Home □ Birthing Center _______ □ Hospital ___________

Birth Weight:____________ Birth Length:____________ Apgar Scores:____________

At birth: Jaundice (yellow) □ Yes □ No Cyanosis (blue) □ Yes □ No

Medication taken during pregnancy? □ Yes □ No _____________________________________ Epidural: □ Yes □ No

Please list any problems during pregnancy and/or labor:____

____

____

Congenital Anomalies/Defects:____

Infant Feeding: □ Breast □ Bottle □ Formula Other food or drink information:_________________________________

____

#of hours child sleeps daily:____________ Quality of sleep: □ Good □ Fair □ Poor

Explain:____

# of siblings:_______ Please list names and ages:____

MEDICAL INFORMATION

Pediatrician and/or Family MD Name:__________________________________ Location:__________________________

Date of last visit to doctor:_______________ Purpose of that visit:____

____

Immunization History:____

____

Has your child ever been treated on an emergency basis? □ Yes □ No Please describe:_____________________________

____

HEALTH INFORMATION

Reason for visit today:____
____
Condition started on:____
Is condition getting progressively worse? □ Yes □ No Please describe:____
Other doctors seen for this condition

:____
Any home remedies?____

DEVELOPMENTAL HISTORY- at what age did the child:	CHILDHOOD DISEASES- age of the child when occurred:
Respond to sound: __________	Chicken pox: __________
Crawl: __________	Rubella: __________
Follow an object with their eyes: __________	Rubeola: __________
Hold head up: __________	Whooping cough: __________
Stand: __________	Mumps: __________
Sit alone: __________	Measles: __________
Walk alone: __________	Other: __________

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

□ Diabetes	□ Bed Wetting	□ Convulsions	□ Neck Problems
□ Fainting	□ Tuberculosis	□ Backaches	□ Heart Trouble
□ Dizziness	□ Stomach Aches	□ Allergies	□ Orthopedic Problems
□ Asthma	□ Walking Problems	□ Rheumatic Fever	□ Hypertension
□ Sugar Concentration	□ Headaches	□ Blood Disorders	□ Broken Bones
□ Sleeping Problems	□ Digestive Disorders	□ Sinus Trouble	□ Leg Problems
□ Diarrhea	□ Constipation	□ Paralysis	□ Joint Problems
□ Arm Problems	□ Hyperactivity	□ Chronic Earaches	□ Colds/Flu
□ Arthritis	□ Neuritis	□ Anemia	□ Poor Appetite
□ Behavioral Problems	□ Muscle Jerking	□ Ruptures/Hernias	□ "Growing Pains"

□ Any other Problem: ____

Present Health History or Additional Information: ____
____
Has the child had any surgeries? □ Yes □ No What and When? ____
____
Accidents: ____

MEDICATIONS: ______________________________	VITAMINS: ______________________________
____	____
____	____

Family Health History

	Heart Disease	Arthritis	Cancer	Diabetes	Other ______________
Father's Side	❒	❒	❒	❒	❒
Mother's Side	❒	❒	❒	❒	❒

Upon the completion of your first visit, you will receive a Chiropractic Report to discuss the different types of Active Life Plans that are available to you. Chiropractic Active Life Plans are designed to help get you feeling better quickly and to help you and your family be as healthy as possible. Please review the explanations of the Chiropractic Active Life Plans prior to your Chiropractic Report appointment so you can choose the level of participation that supports you in reaching all of your health goals.

_________________________________ _________________________________ _________________________________
Parent's Signature Relationship to Patient Date