Omer Chiropractic
Lifestyle Center
"Creating Healthier Tomorrows"

PEDIATRIC PATIENT INFORMATION

Child's Name: _____ Gender: M / F Today's Date: _____

Mother's Name: _____ Father's Name: _____ # of Siblings: _____

Address: _____ City: _____ State: ___ Zip: _____

Home Phone: _____ Mother's Phone: _____ Father's Phone: _____

Birthdate: _____ Age: _____ Birth Weight: _____ Current Weight: _____

Birth Length: _____ Current Height: _____

Type of Birth: ☐ Normal Vaginal ☐ Forceps ☐ Breech ☐ C-Section

Where was the Birth: ☐ Home ☐ Birthing Center ☐ Hospital ☐ Other

Pregnancy History / Problems: _____

_____

_____

Birth / Delivery History or Problems: _____

_____

_____

Congenital Anomalies / Defects: _____

Infant Feeding: ☐ Breast ☐ Bottle ☐ Formula

Quality of Sleep: ☐ Good ☐ Fair ☐ Poor

Obstetrician / Midwife: _____
NAME LOCATION

Pediatrician / Family MD: _____
NAME LOCATION

Date of Last Visit to MD: _____ Purpose: _____

Immunization History: _____

Has your child ever been treated on an emergency basis? ___ If so, describe: _____

_____

Purpose of Today's Appointment: _____

_____

_____

_____

OVER

PEDIATRIC PATIENT INFO
(Continued)

Developmental History: At What Age Did the Child:

Hold Head Up:_____ Sit Alone:_____ Crawl:_____ Stand:_____ Walk Alone:_____

Has this Child Ever had Childhood Diseases:

- ☐ Chickenpox
- ☐ Mumps
- ☐ Measles
- ☐ Rubella
- ☐ Rubeola
- ☐ Whooping Cough
- ☐ Other _____

Has this Child Ever Suffered From:

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

Surgeries: _____

_____

Medications: _____

_____

Accidents: _____

_____

Family History (anything you feel may pertain to the child's health): _____

_____

How did you hear about our office? (whom may we thank for referring you to us?): _____

_____

AUTHORIZATION FOR CARE OF A MINOR

I HEREBY AUTHORIZE THIS OFFICE AND IT'S DOCTOR(S) TO ADMINISTER CARE AS THEY SO DEEM NECESSARY TO MY SON / DAUGHTER / WARD (UPON APPROVAL OF PARENT OR GUARDIAN).

SIGNATURE: _____ DATE: _____

I REALIZE THAT I AM RESPONSIBLE FOR ALL FEES CHARGED BY THIS CLINIC AND THAT I WILL PAY FOR ALL SERVICES AS THEY ARE PERFORMED. X-RAYS REMAIN THE PROPERTY OF THIS CLINIC.

SIGNATURE: _____ DATE: _____