TOOELE CHIROPRACTIC

293 N Main St
Tooele, UT 84074
(435)882-1621

Pediatric Information

3 years - 13 years

Name (full name please) _____Date _____

Address_____ City _____ State _____ Zip _____

Date of Birth _____Home Phone _____ Cell Phone (Parent's)_____

Age_____ Gender_____ Height_____ Weight _____ Ages of Siblings _____

Has child had chiropractic care before? Yes No DC's Name_____

Child's medical doctor and address _____

Date of last doctor's visit _____ Reason _____ Referred by _____

Parent's email address _____

General Health History

Typical sleep patterns (day and night) _____

Has your child had colic? Yes No Asthma? Yes No Upper respiratory infections? How often?_____

Does your child complain of pain in their back, neck, arms, or legs? _____

Does your child complain of headaches? _____

Does your child complain of earaches? Yes No How Often?_____ Age when earache first occurred___

Do the earaches tend to occur in the same ear? Yes No Right Left Both

List approximate date of any other illnesses _____

Is your child receiving any medications?_____

List any immunizations and any reactions observed _____

Has your child had any illness or injuries that have required a hospitalization or surgery?_____

_____

List any significant family history (asthma, cancer, diabetes, etc.) _____

_____

Has your child had any recent falls or trauma?_____

Has your child fallen down stairs or from any height? _____

Has your child been in a motor vehicle collision or near-miss? _____

Has your child had a bone fracture or joint dislocation?_____

Does your child bang his/her head repeatedly against a wall, bed, or other object?_____

Nutritional History

Does your child have any food intolerances or allergies? Type? _____

Does your child have any persistent or intermittent skin rashes? _____

Is your child receiving any vitamin supplements? _____

History of Concern

Reason for contacting us _____Date of onset _____

How did symptoms start? Sudden Gradual Are symptoms - Constant Intermittent Occasional

Initiating factors _____

What makes the concern better? _____

What makes the concern worse? _____

Has this interfered with your child's daily activities? Yes No In what way?_____

What do you believe caused this concern? _____

Authorization to Treat Minors

I, _____, give my consent to Dr. Matt Peterson, DC to evaluate and treat my son/daughter, _____

_____ _____

Authorized Signature Date

Please fill in information as completely as possible so insurance claims are accurate

Name of policy holder _____ Relationship to Patient _____

Policy holder's address (if different from patient's)_____

Phone# _____ Date of birth _____

Policy holder's employer (and address) _____

_____

Insurance Company _____Insured's ID number _____

Insurance Company's address _____

Insurance Company's Phone # _____ Fax # _____