



# TOOELE CHIROPRACTIC

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

## Pediatric Information

Nine Months - Two 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 \_\_\_\_\_

## Prenatal and Delivery History

Prenatal care? Yes No Chiropractic care through pregnancy? Yes No  
Any trauma or possible toxic exposure during pregnancy? \_\_\_\_\_  
List any complications during pregnancy \_\_\_\_\_  
Gestation of pregnancy \_\_\_\_\_ Place of birth \_\_\_\_\_  
Type of Delivery: Vaginal C-Section Breech Hours of labor \_\_\_\_\_  
List any complications during delivery (forceps, vacuum, cord problems, etc.) \_\_\_\_\_  
\_\_\_\_\_  
List any medications taken during delivery \_\_\_\_\_  
List any concerns at birth (nursing, breathing, color, etc.) \_\_\_\_\_  
\_\_\_\_\_  
List any procedures performed at birth to Mom or Baby (surgery, artificial feeding, etc.) \_\_\_\_\_  
\_\_\_\_\_

## Nutritional History

Breastfed? Yes No Duration \_\_\_\_\_ Formula - type and when started \_\_\_\_\_  
Cow's milk began at age \_\_\_\_\_ Other milk? Yes No Type: \_\_\_\_\_ Age \_\_\_\_\_ Solid food began age \_\_\_\_\_  
Were commercially prepared baby foods used? Yes No Food intolerance? Yes No Type: \_\_\_\_\_  
Does your child have any persistent or intermittent skin rashes? \_\_\_\_\_  
Is your child receiving any vitamin supplements? \_\_\_\_\_

## General Health History

Typical sleep patterns (day and night) \_\_\_\_\_

Age when started... Teething \_\_\_\_\_ Rolling \_\_\_\_\_ Crawling \_\_\_\_\_ Walking \_\_\_\_\_

Climbing \_\_\_\_\_ Babbling/Talking \_\_\_\_\_ Sitting Up \_\_\_\_\_

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? \_\_\_\_\_

## 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 # \_\_\_\_\_