TOOELE CHIROPRACTIC

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

Pediatric Information

Infant - Nine Months

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 Nn 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 ____

Apgar scores ________________ Weight at birth _____________ Length at birth _________________

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___________

General Health History

Typical sleep patterns (day and night) ____
Age when started... Teething________ Rolling______ Crawling______ Walking________
Climbing ________ Babbling/Talking___________
List any immunizations and any reactions observed ______________________________________
____
List any significant family history (asthma, cancer, diabetes, etc.) ______________________
____
List any other significant information ____
____

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 # __________________