A. Little Chiropractic Center

DR. ALICIA LITTLE

1012 Ralston Avenue
Defiance, OH 43512
419-782-2272

Pediatric Patient Information Form

Name_____ Date_____Parent or Guardian_____

Address_____ City_____ State_____ Zip_____

Email Address_____ Home Phone_____

Date of Birth_____ Age_____ Sex M F

SS#_____ Language_____

Race: (Please circle one)

White Hispanic American Indian or Alaska Native Black or African American Asian Native Hawaiian or Pacific Islander Other

Ethnicity: (Please circle one)

Hispanic or Latino Not Hispanic or Latino Decline

Has the patient ever received chiropractic care? Yes No How long ago?_____

Reason for seeking care:_____

MEDICAL HISTORY: Check the following conditions that your child has suffered from: (Please elaborate on all marked boxes as appropriate in the space provided)

ADD/ADHD □ Constipation □ Fatigue □ Orthopedic Conditions □ Allergies □ Diabetes □ Headaches
□ Scoliosis □ Asthma □ Digestive Problems □ Hearing Difficulties □ Seizures □ Blood Disorder
□ Depression/ Anxiety □ Heart Problems □ Sleep Disturbances □ Chronic Colds □ Dyslexia □ Kidney Disorders
□ Torticollis □ Colic □ Ear Infections □ Lymph Disorders □ Vision Difficulties □ Autism
□ Sensory Processing Challenges □ Other_____

Current Medications:_____

Has your child ever had surgery? □ No □Yes _____

PRENATAL HISTORY: Were there any complications or unusual stressors during the pregnancy? □ Yes □ No

_____

Medications during pregnancy? □ Yes □ NO _____

Cigarette/ Alcohol use during pregnancy? □ Yes □ No _____

BIRTH HISTORY: Was the delivery premature or full-term? Gestational Age:_____ Was the delivery via C-Section or vaginal delivery?_____ Was the delivery an emergency? _____ Were forceps used in the delivery? □ Yes □ No Vacuum Extraction? □ Yes □ No

Any complications during the delivery? □ Yes □ No _____

Birth Weight: Length: _____ APGAR scores: at one minute_____, at five minutes_____

Was the use of oxygen required? □ Yes □ No Did your child require additional hospitalization? □ Yes □ No

_____

Was your child bottle, breast-fed or both? _____

Did your child have difficulty latching on or any sucking difficulties? □ Yes □ No_____

DEVELOPMENTAL HISTORY: (Physical, Speech, Emotional, Social, Academic)

Please tell us about your child's development.

Did he/she show signs of delay or advancement? _____

Age when he/she rolled over:_____ sat up unsupported:_____ crawled:_____ walked:_____ spoke his/her first word:_____ spoke in sentences:_____ became toilet trained:_____

Does he/she show any signs of food allergies/intolerances? □ Yes □ No _____

Is / has your child been involved in any high impact or contact type sports (i.e., Soccer, Football, Gymnastics, Baseball, Cheerleading, Martial Arts, Wrestling, etc.) ? □ Yes □ No List:_____

_____

Has Your Child Ever Been Involved in a Car Accident ? □ Yes □ No _____

Has Your Child Been Seen on an Emergency Basis? □ Yes □ No, List: _____

Other Traumas Not Described Above ? □ Yes □ No, List: _____

Does your child tend to fall frequently? □ Yes □ No Does your child show any signs of muscle weakness? □Yes □ No

I hereby authorize this office and its doctors to administer care to my Son / Daughter as deemed necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Signature of Parent or Guardian_____Date_____