Vitality
INSTITUTE OF HEALTH

# PEDIATRIC PATIENT INFORMATION

CHILD'S NAME_________________________________ DOB __________________ AGE____________ SEX_____________

MOTHER'S NAME _______________________________________DOB_________________
FATHER'S NAME _______________________________________DOB_________________

ADDRESS_________________________________________CITY______________________STATE_______ZIP_____________

HOME PHONE____________________________ MOTHER'S CELL #________________________MOTHER'S WORK #_____________________
EMAIL___________________________________FATHER'S CELL #________________________FATHER'S WORK #______________________

3rd TRIMESTER PRESENTATION: VERTEX______BREECH______TRANSVERSE_______FACE/BROW_______
TYPE OF BIRTH: NORMAL VAGINAL_______ FORCEPS________CESAREAN_______ SUCTION CAP OR VACUUM______
LOCATION: HOME_______ BIRTHING CENTER_______ HOSPITAL_________
PROBLEMS DURING PREGNANCY:_____________________________________________________________________________________________
CONGENITAL ANOMALIES/DEFECTS___________________________________________________________________________________________

INFANT FEEDING: BREAST______ BOTTLE_______ IF BOTTLE, WHICH FORMULA?__________________________________
#OF HOURS SLEEPING PER NIGHT____________ QUALITY OF SLEEP: GOOD_______ FAIR________ POOR_______

OBSTERTICIAN/MIDWIFE_____________________________________________________________________________________________
PEDIATRICIAN/FAMILY MD___________________________________________________________________________________________
DATE OF LAST VISIT__________________________ PURPOSE___________________________________________________________________
IMMUNIZATION HISTORY_____________________________________________________________________________________________
PREVIOUS CHIROPRACTOR___________________________________________________________________________________________
HAS YOUR CHILD BEEN TREATED ON AN EMERGENCY BASIS?_________
IF YES, PLEASE EXPLAIN____________________________________________________________________________________________

PURPOSE OF THIS APPOINTMENT____________________________________________________________________________________
INSURANCE/BILLING INFORMATION_____________________________________________ID #________________________________________

DELIVERY/BIRTH HISTORY:
______________________________________________________________________________________________________________
______________________________________________________________________________________________________________
______________________________________________________________________________________________________________

AT WHAT AGE, IF EVER, DID THIS CHILD SUFFER FROM THE FOLLOWING CHILDHOOD DISEASES?
CHICKENPOX___________________ MUMPS___________________MEASLES____________________RUBELLA_____________________
RUBEOLA_____________________WHOOPING COUGH______________________ OTHER_______________________________________

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HAS THIS CHILD EVER SUFFERED FROM ANY OF THE FOLLOWING?

- ☐ HEADACHES
- ☐ DIZZINESS
- ☐ FAINTING
- ☐ SEIZURES/CONVULSIONS
- ☐ HEART TROUBLE
- ☐ CHRONIC EARACHES
- ☐ SINUS TROUBLE
- ☐ ASTHMA
- ☐ COLDS/FLU
- ☐ COLIC
- ☐ ORTHOPEDIC PROBLEMS
- ☐ NECK PROBLEMS
- ☐ ARM PROBLEMS
- ☐ LEG PROBLEMS
- ☐ JOINT PROBLEMS
- ☐ BACKACHES
- ☐ POOR POSTURE
- ☐ SCOLIOSIS
- ☐ WALKING TROUBLE
- ☐ BROKEN BONES
- ☐ DIGESTIVE DISORDERS
- ☐ POOR APPETITE
- ☐ STOMACH ACHES
- ☐ REFLUX
- ☐ CONSTIPATION
- ☐ DIARRHEA
- ☐ DIABETES
- ☐ HYPERTENSION
- ☐ ANEMIA
- ☐ BED WETTING
- ☐ BEHAVIORAL PROBLEMS
- ☐ ADD/ADHD
- ☐ RUPTURES/HERNIA
- ☐ MUSCLE PAIN
- ☐ GROWING PAINS

☐ ALLERGIES_______________________________________________________

☐ OTHER _________________________________________________________

HAS THIS CHILD EVER SUFFERED FROM THE FOLLOWING SPINAL TRAUMAS?

- ☐ FALL IN BABY WALKER
- ☐ FALL FROM CRIB
- ☐ FALL FROM HIGHCHAIR
- ☐ FALL FROM CHANGING TABLE
- ☐ FALL FROM BED OR COUCH
- ☐ FALL OFF SWING
- ☐ FALL OFF SLIDE
- ☐ FALL OFF MONKEY BARS
- ☐ FALL OF SKATEBOARD OR SKATES
- ☐ FALL OFF BICYCLE
- ☐ FALL DOWN STAIRS

☐ OTHER__________________________________________________________

HAS THIS CHILD EVER SUSTAINED AN INJURY PLAYING ORGANIZED SPORTS? _______________

If YES, PLEASE EXPLAIN ____________________________________________________________________________________________________

HAS THIS CHILD EVER SUSTAINED INJURIES IN AN AUTO ACCIDENT?______________

IF YES, PLEASE EXPLAIN ______________________________________________________________

PRESENT HISTORY____________________________________________________________________________________________________

____________________________________________________________________________________________________

____________________________________________________________________________________________________

____________________________________________________________________________________________________

MEDICATIONS ____________________________________________________________________________________________________

FAMILY HISTORY ____________________________________________________________________________________________________

REFERRED BY___________________________________________

## AUTHORIZATION FOR CARE OF MINOR

I HEREBY AUTHORIZE THIS OFFICE AND ITS DOCTOR(S) TO ADMINISTER CARE AS THEY SO DEEM NECESSARY TO MY CHILD.

SIGNED_________________________________WITNESSED_________________________________DATE_______________

I REALIZE THAT I AM RESPONSIBLE FOR ALL FEES CHARGED BY THIS OFFICE AND I AGREE TO PAY FOR ALL SERVICES PROVIDED.

SIGNED _________________________________________ DATE___________________

2001 South Barrington Ave., Suite 212 Los Angeles, CA 90025 · Tel. 310.473.8191 · vitalityinstituteofhealth@gmail.com