

PEDIATRIC PATIENT INTRODUCTION

'A' Street Clinic of Chiropractic, PLLC
Donald W. Olson, DC, FASBE, DACS, Auburn, WA

CHILD'S NAME: _____ HOME PHONE: _____

STREET ADDRESS: _____ APT/LOT NUMBER: _____

CITY/TOWN: _____ STATE: _____ ZIP: _____

MOTHER'S NAME: _____ MOTHER'S WORK PHONE: _____

FATHER'S NAME: _____ FATHER'S WORK PHONE: _____

BIRTH DATE: _____ AGE: _____ BIRTH WEIGHT: _____ CURRENT WEIGHT: _____

SEX: _____ NO. OF SIBLINGS: _____ BIRTH LENGTH: _____ CURRENT LENGTH: _____

TYPE OF BIRTH: NORMAL VAGINAL _____ FORCEPS _____ BREECH _____ CESAREAN _____

HOME _____ BIRTHING CENTER _____ HOSPITAL _____

PROBLEMS DURING PREGNANCY: _____

PROBLEMS DURING LABOR/DELIVERY: _____

APGAR SCORES: _____ WAS THERE PRESENCE AT BIRTH OF: _____ JAUNDICE (YELLOW)
_____ CYANOSIS (BLUE)

PURPOSE OF THIS APPOINTMENT: _____

HAS YOUR CHILD EVER BEEN TREATED ON AN EMERGENCY BASIS? _____

DESCRIBE: _____

ANY VACCINATIONS: _____

ANY VACCINATION REACTIONS: IMMEDIATE _____ WITHIN FOLLOWING MONTH(S) _____

CONGENITAL ANOMALIES/DEFECTS: _____

INFANT FEEDING: BREAST _____ BOTTLE _____ FORMULA _____

NO. OF HOURS SLEEP PER NIGHT: _____ QUALITY OF SLEEP: GOOD _____ FAIR _____ POOR _____

OBSTETRICIAN/MIDWIFE: _____

LOCATED AT: _____

PEDIATRICIAN/FAMILY MD: _____

LOCATED AT: _____

DATE OF LAST VISIT TO MD: _____ PURPOSE: _____

INSURANCE/BILLING INFORMATION: _____

_____ POLICY NUMBER: _____

I REALIZE THAT I AM RESPONSIBLE FOR ALL FEES CHARGED BY THIS CLINIC AND THAT I WILL PAY FOR ALL SERVICES PERFORMED. X-RAYS REMAIN THE PROPERTY OF 'A' STREET CLINIC OF CHIROPRACTIC, PLLC

DATE: _____ SIGNATURE: _____

Patient Name:
DOB:

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PEDIATRIC CASE HISTORY

DEVELOPMENTAL HISTORY: AT WHAT AGE DID THE CHILD:

RESPOND TO SOUND CRAWL
FOLLOW AN OBJECT WITH HIS/HER EYES STAND
HOLD HEAD UP WALK ALONE
SIT ALONE

CHILDHOOD DISEASES: CHICKENPOX RUBELLA
MUMPS RUBEOLA
MEASLES WHOOPING COUGH

OTHER ILLNESSES:

HAS THIS CHILD EVER SUFFERED FROM:

- DIIZZINESS BACKACHES HEART TROUBLE CHRONIC EARACHES
DIABETES TUBERCULOSIS HYPERTENSION COLDS/FLU
ARTHRITIS HEADACHES ASTHMA ALLERGIES
NEURITIS DIGESTIVE DISORDERS SINUS TROUBLE CONSTIPATION
ANEMIA RHEUMATIC FEVER ORTHOPEDIC PROBLEMS DIARRHEA
POOR APPETITE HYPERACTIVITY SUGAR CONCENTRATION BEHAVIORAL PROBLEMS
BED WETTING CONVULSIONS PARALYSIS MUSCLE JERKING
FAINTING WALKING PROBLEMS BROKEN BONES RUPTURES/HERNIAS
NECK PROBLEMS ARM PROBLEMS LEG PROBLEMS "GROWING PAINS"
JOINT PROBLEMS BLOOD DISORDERS STOMACH ACHES OTHER

PRESENT HISTORY:

SURGERY:

MEDICATIONS:

ACCIDENTS:

FAMILY HISTORY:

AUTHORIZATION FOR CARE OF MINOR

I HEREBY AUTHORIZE THIS CLINIC AND IT'S DOCTOR(S) TO ADMINISTER CARE AS THEY SO DEEM NECESSARY TO MY SON / DAUGHTER / WARD (UPON APPROVAL OF PARENT OR GUARDIAN).

SIGNED: WITNESSED: DATE: