BACK TO WELLNESS CLINIC OF RUTLEDGE

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Rutledge, GA 30663

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PEDIATRIC PATIENT INFORMATION

PATIENT INFORMATION:

CHILD'S NAME: _____
LAST FIRST MIDDLE

MOTHER'S NAME:
_____
LAST FIRST MIDDLE

FATHER'S NAME: _____
LAST FIRST MIDDLE

ADDRESS: _____
STREET CITY/STATE ZIP

HOME PHONE: _____ **PARENT CELL PHONE:**_____

MOTHER'S WK PHONE: _____ **FATHER'S WK PHONE:**_____

EMAIL ADDRESS: _____

PURPOSE OF THIS APPOINTMENT: _____

_____

PATIENT BIRTH HISTORY:

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

BIRTH LENGTH: _____ **CURRENT LENGTH/HEIGHT:** _____
SEX: _____

TYPE OF BIRTH: VAGINAL _____ **FORCEPS** _____ **BREECH** _____ **CESAREAN** _____
HOME _____

BIRTHING CENTER _____ **HOSPITAL** _____

WAS THEIR PRESENCE AT BIRTH OF JAUNDICE (YELLOW) _____ **CYANOSIS (BLUE)** _____

CONGENITAL ANOMALIES/DEFECTS: _____

DELIVERY/BIRTH HISTORY:
_____

INFANT FEEDING: BREAST _____ **BOTTLE** _____ **FORMULA** _____

DAILY HABITS

NUMBER OF HOURS SLEEPING PER NIGHT: _____

QUALITY OF SLEEP: GOOD _____ **FAIR** _____ **POOR** _____

WHAT VITAMINS DOES YOUR CHILD TAKE: _____

DOES YOUR CHILD DRINK CAFFEINE BEVERGES? _____ **HOW MUCH?** _____

HEALTH HISTORY

Check only those conditions which are applicable?

□ **Dizziness**	□ **Backaches**	□ **Heart Trouble**	□ **Chronic Earaches**
□ **Diabetes**	□ **Tuberculosis**	□ **Hypertension**	□ **Colds/Flu**
□ **Arthritis**	□ **Headaches**	□ **Asthma**	□ **Allergies**
□ **Neuritis**	□ **Digestive Disorder**	□ **Sinus Trouble**	□ **Constipation**
□ **Anemia**	□ **Rheumatic Fever**	□ **Orthopedic Problem**	□ **Diarrhea**
□ **Poor Appetite**	□ **Hyperactivity**	□ **Sugar Concentration**	□ **Behavioral Problems**
□ **Bed Wetting**	□ **Convulsions**	□ **Paralysis**	□ **Muscle Jerking**
□ **Fainting**	□ **Walking Problems**	□ **Broken Bones**	□ **Hernias**
□ **Neck Problems**	□ **Arm Problems**	□ **Leg Problems**	□ **Growing Pains**
□ **Joint Problems**	□ **Blood Disorders**	□ **Stomach Aches**	□ **Other**

List any surgeries/dates the child has had: _____

_____

List any accidents the child has had: _____

_____

List any allergies your child has: _____

_____

List all medications the child is taking: _____

_____

CHILDHOOD DISEASES

□ **Chicken pox**	□ **Rubella**
□ **Mumps**	□ **Whooping Cough**
□ **Measles**	□ **Other**

DEVELOPMENT HISTORY

At what age did the child:

Respond to sound _____
Follow an object _____
Hold head up _____
Sit alone _____
Crawl _____
Stand _____
Walk alone _____

AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize Back to Wellness Clinic and it's Doctor(s) to administer care, as they so deem necessary for my child/dependent. I authorize Back to Wellness to release any information including the diagnosis and the records of any treatment rendered to my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the Back to Wellness Clinic insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for service. I agree to be responsible for payment of all services rendered on my dependents.

SIGNED: _____

NAME **DATE**

WITNESS: _____

NAME **DATE**