PEDIATRIC PATIENT INFORMATION AND HISTORY

Welcome to our office, please complete this form in order for us to provide you with the best possible care.

Child's Name:_____
Mother's Name_____ Father's Name:_____
Address:_____ City:_____ Province:_____ Postal code:_____
Home phone:_____ Mother's work phone:_____ Cell phone:_____
Email:_____ Father's work phone: _____ Cell phone: _____

Birth date:_____ Age: ____Sex: ___ Number of siblings: ____ Referred by: _____
Birth weight:_____Birth Length: _____Current weight: _____Current length:_____

Third trimester presentation: Vertex: _____ Breech: _____ Transverse:_____ Other: _____
Type of Birth: Vaginal_____ Forceps_____ Ceserean_____ Suction or Vacuum _____
Location: Home_____ Birthing Center_____ Hospital _____
Duration of gestation:_____ Medications given to mother at birth:_____
Problems during pregnancy: _____
Problems during labour/delivery:_____
Agpar scores at birth: ___ After 5 mins ___
Was there presence at birth of: Jaundice (yellow)___ Cyanosis (blue)____
Congenital anomalies/defects_____If yes, please explain:_____

Was this child breastfed? ☐ Yes ☐ No How long_____ Formula introduced at age_____
Type of formula_____ Introduction of Cow's milk at age_____ Of solid food at age_____
Type of food introduced_____ Food/Juice intolerance ☐ Yes ☐ No Type:_____
Any illnesses of the mother during pregnancy:_____
Supplements or drugs taken by the mother during pregnancy:_____
Exposures to ultrasound? ☐ Yes ☐ No If yes, how many and what was the medical reason?_____
_____

Obstetrician/Midwife:_____
Pediatrician/Family MD:_____
Date of Last Visit:_____ Purpose:_____
Immunization History:_____
Any Reactions to immunizations?_____
Number of doses of antibiotics taken: During the past six months____ During his/her lifetime _____
Previous chiropractor:_____
Date of last visit:_____ Purpose for Visit:_____
Has your child ever been treated on an emergency basis?____If yes, please explain:_____
_____

Number of hours of TV watched per week_____ Number of hours of physical activity per week_____

Purpose of this appointment:_____
_____
_____
_____
_____

grandview health group ltd.
Dr. Kevin Dieleman ● Dr. Laura Iverson
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At what age did the child:

Respond to sound_____ Follow an object with his/her eyes_____ Hold Head Up_____
Sit Alone_____ Crawl _____ Stand _____ Walk alone _____

At what age, did this child suffer from the following childhood diseases?

Chickenpox_____ Mumps_____ Measles_____ Rubella_____
Rubeola_____ Whooping cough_____ Other_____

Has this child ever suffered from:

☐ Headaches	☐ Orthopedic problems	☐ Digestive Disorders	☐ Behavioural problems
☐ Dizziness	☐ Neck problems	☐ Poor appetite	☐ ADD/ADHD
☐ Fainting	☐ Arm problems	☐ Stomach aches	☐ Ruptures/hernia
☐ Seizures/convulsions	☐ Leg problems	☐ Reflux	☐ Muscle pain
☐ Heart trouble	☐ Joint problems	☐ Constipation	☐ Growing pains
☐ Chronic earaches	☐ Backaches	☐ Diarrhea	☐ Allergies to _____
☐ Sinus trouble	☐ Poor posture	☐ Diabetes	☐ Allergies to _____
☐ Asthma	☐ Scoliosis	☐ Hypertension	☐ Other_____
☐ Colic	☐ Walking trouble	☐ Anemia	☐ Other_____
☐ Bed Wetting	☐ Broken bones	☐ Colds/Flu	☐ Other_____

Has this child ever suffered from the following spinal traumas?

☐ Fall from bed or couch	☐ Fall off skateboard/skates	☐ Fall off bicycle
☐ Fall off swing	☐ Fall from crib	☐ Fall from highchair
☐ Fall down stairs	☐ Fall off monkey bars	☐ Fall from changing table
☐ Other_____	☐ 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,_____
_____
Surgeries:_____
Medications:_____

AUTHORIZATION FOR CARE OF A MINOR

I HEREBY AUTHORIZE THIS OFFICE AND ITS DOCTOR(S) TO ADMINISTER CARE AS THEY SO DEEM NECESSARY TO MY SON/DAUGHTER (UPON APPROVAL OF PARENT OR GUARDIAN)

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:**_____

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