Dobbs Ferry Chiropractic
& Holistic Health Center
63 Main Street, Dobbs Ferry, NY
T: 914.693.4545 / F: 914.231.6672

PEDIATRIC REGISTRATION & HISTORY

Child's Name:____

Address:_________________________ City:__________________ State:_______ Zip:_______

Home Phone:___________________________________ Cell Phone:________________

1st Parent's Name:__________________________ Work Phone:________________

2nd Parent's Name:__________________________ Work Phone:________________

Social Security No:____________________ Email Address:__________________________

Birth date:______________ Age:_______ Sex: M / F Number of siblings:________________

Birth Weight:____________ Current Weight:_______

Birth Length:____________ Current Length:_______

Type of birth (check all that apply) [ ] Normal Vaginal [ ] Forceps [ ] Vacuum

[ ] Breech [ ] C-section [ ] Home

[ ] Birth Center (name) ______________________________

[ ] Hospital (name) ________________________________

Problems during pregnancy: ______________________________________

Problems during labor delivery:____________________________________

APGAR Scores:__________ At birth, was there a presence of: Jaundice (yellow)

Cyanosis (blue)

Congenital anomalies/defects: ______________________________________

Infant Feeding - Please list at what age the child received each method.

Breast ________ Bottle ________ Formula ________

Number hours sleep per night:_______ Quality of sleep: Good / Fair / Poor Explain:______________

Obstetrician/Midwife:____

Pediatrician: ____

Date of last visit to MD:__________ Purpose:___________________________

Immunization History:____

Has your child ever been treated on an emergency basis? Y / N Explain:__________________

Purpose of today's appointment:_____________________________________

Whom may we thank for referring you to our office?_____________________

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PEDIATRIC REGISTRATION & HISTORY

PERSONAL HEALTH HISTORY Has this child ever suffered from:

[ ] Dizziness
[ ] Tuberculosis
[ ] Headaches
[ ] Digestive trouble
[ ] Anemia
[ ] Poor appetite
[ ] Convulsions
[ ] Walking problems
[ ] Arm problems
[ ] Blood disorders
[ ] Backaches
[ ] Colds/Flu
[ ] Asthma
[ ] Sinus trouble
[ ] Rheumatic Fever
[ ] Hyperactivity
[ ] Paralysis
[ ] Broken Bones
[ ] Leg Problems
[ ] Stomach Aches
[ ] Heart trouble
[ ] High blood pressure
[ ] Neuritis
[ ] Constipation
[ ] Orthopedic
[ ] Sugar concentration
[ ] Muscle jerking
[ ] Ruptures/Hernia
[ ] "Growing Pains"
[ ] Joint problems
[ ] Diabetes
[ ] Arthritis
[ ] Colic
[ ] Bed-wetting
[ ] Diarrhea
[ ] Behavioral problem
[ ] Fainting
[ ] Neck problems
[ ] Chronic Ear Infections

Surgeries: ____________________

Medications (name & purpose): ____________________

Allergies: ____________________

FAMILY HEALTH HISTORY
Please place a check mark if someone in the child's <u>immediate family</u> has had the following.
Please write <u>how they are related</u> to the child.

[ ] Back Problems ____________________
[ ] High pressure ____________________
[ ] Thyroid Disorder ____________________
[ ] Stroke ____________________
[ ] Diabetes ____________________
[ ] Osteoporosis ____________________
[ ] Headaches ____________________
[ ] Ulcer/Digestive Problem ____________________
[ ] Heart Disease ____________________
[ ] Arthritis ____________________
[ ] Cancer ____________________
[ ] Mental Illness ____________________

WELLNESS PROFILE
Chiropractic care affects more than just our muscles and bones. <u>Please share with us what health goals you hope to find for this child</u>. Check as many boxes as you wish

[ ] More energy
[ ] Better concentration
[ ] Try quality vitamins
[ ] Reduce medications
[ ] Enhanced emotional well-being
[ ] Better sleep
[ ] Easier breathing
[ ] Improve nutrition
[ ] Improve overall health
[ ] Greater resistance to disease
[ ] Freedom from pain
[ ] More balanced posture
[ ] Improved coordination
[ ] Better sports performance
[ ] Other