Pediatric Registration & History

Ashland Natural Medicine
739 N Main Street
Ashland, Oregom 97520

Patient Information

Date_____ Birth Date _____
Patient Name _____
Sex M F
Address _____
City _____ State _____
Zipcode_____
Phone Number _____

Has the patient had Chiropractic care before?_____
Referred by _____
Is the patient currently under the care of a another Physician? **Y N**
If yes Who?_____

Phone Numbers

Name of emergency contact_____
Emergency contact number_____

Medical Doctors Name _____

Medical Doctors Number _____

Insurance Information

Insured's Name_____

Relationship to Patient_____

Insurance Carrier_____

Responsible Party Information

Relationship to patient_____
Address_____
City _____State_____
Zip Code_____

Other Information

Authorization for care

I have read the above information and certify it to be true and correct and to the best of my knowledge, and hereby authorize this office of Chiropractic to provide my child with chiropractic care, in accordance with this states statutes

Patient or Guardian signature_____

Date_____

To help us serve you better please complete all of the following information. We look forward to working with you to build better health for you and your family.

Pediatric Chief Complaint History

Patient Name_____

What are your reasons for bringing your child into the office today?

When did this/these complaints begin?_____
_____
Is it getting worse? **Y N** What seemed to be the initial cause? _____
Have you seen any other physicians for this/these conditions? **Y N**
Name of Physician and prior treatments_____
_____
Is your child under the care of another physician for another reason **Y N** if yes, for what reason?_____
_____
Has your child been hospitalized in the last 10 years? **Y N** If yes, for what reason?_____
_____

Number of doses of antibiotics your child has taken:
During the past six months:_____ Total during her/his lifetime:_____

Number of doses of other prescription medications your child has taken:
During the past six months: _____Total during her/his lifetime: _____List:_____
_____

Please **list** all ***supplements/herbs/homeopathics/vitamins*** your child is currently taking or has in the last year
_____
_____
_____
Please **list** all **medications** your child is currently taking
_____
_____
Please describe the child's birth (at home, caesarean, hospital, adopted, etc..)_____
_____

Birth Interventions

_____Forceps _____Caesarean: emergency or planned (please circle) _____Vacuum extraction
_____Labor induced with drugs _____Other emergency procedures
At how many weeks was the child born?_____

Please **check** if there was a history of…

____**Maternal Hypertension** _____ **Proteinuria** _____**Gestational diabetes**
____**Cigarette use during pregnancy** _____**Alcohol use during pregnancy** _____**Recreational drugs**
____**Medications used during pregnancy**: If yes please list_____

Child's Birth Weight_____
Did your child come out head or feet first? _____
Which way was your child facing when they were delivered? Towards the front or towards the back?_____

Pediatric History Cont.

*Patient Name*_____

What sports/activities is your child involved in?_____

_____

To the best of your knowledge please list all of the vaccinations your child has received and when.

_____

_____

_____

Any reactions from above vaccines? Y N If yes please explain_____

_____

Breast fed: Y N How long?_____

Family Health History

Information about your child's immediate family members (brothers, sisters, parents and grandparents) is crucial to our understanding of your child's total health picture.

Is there any family history of any of the following conditions (circle please) Cancer / High Blood pressure / Tuberculosis / Psoriasis / Diabetes / Syphillis / Depression

Relationship	Alive/Deceased	Age at death	Present and Past Health Problems

Has your child ever:	Yes	No	If yes, briefly explain.
- had a broken bone?	☐	☐	_____
- been hospitalized?	☐	☐	_____
- had strains or sprains?	☐	☐	_____
- used a cane, crutch or other support?	☐	☐	_____
- been struck unconscious?	☐	☐	_____
- been hospitalized other than surgery?	☐	☐	_____

Does your child:			
- have any drug allergies?	☐	☐	_____
- have any food allergies	☐	☐	_____
How were they discovered?			_____
			_____

HABITS	None	Light	Mod	Heavy
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐
Soft Drinks	☐	☐	☐	☐
Salty Foods	☐	☐	☐	☐
Water	☐	☐	☐	☐
Sugar	☐	☐	☐	☐
Sweeteners	☐	☐	☐	☐

When was your child's last:	Never	0-6 mos.	6 -18 mos.	longer
- spinal x-ray?	☐	☐	☐	☐
- spinal examination?	☐	☐	☐	☐
- physical examination?	☐	☐	☐	☐

Pediatric Past Health History

Patient Name_____

Your doctors here at the clinic are interested in all aspects of your health. Please check the degree of all conditions you currently have or have had. To be responsible for ***your*** case, we need your complete health history.

O = Occasional	F = Frequent	C = Constant

O F C

Muscle / Joint

- ☐ ☐ ☐ Arthritis
- ☐ ☐ ☐ Bursitis
- ☐ ☐ ☐ Foot trouble
- ☐ ☐ ☐ Hernia
- ☐ ☐ ☐ Low back pain
- ☐ ☐ ☐ Lumbago
- ☐ ☐ ☐ Neck pain, stiffness
- ☐ ☐ ☐ Pain between shoulders

General

- ☐ ☐ ☐ Allergy
- ☐ ☐ ☐ Anxiety
- ☐ ☐ ☐ Chills
- ☐ ☐ ☐ Convulsions
- ☐ ☐ ☐ Dizziness
- ☐ ☐ ☐ Fainting
- ☐ ☐ ☐ Fatigue
- ☐ ☐ ☐ Fever
- ☐ ☐ ☐ Headache
- ☐ ☐ ☐ Loss of sleep
- ☐ ☐ ☐ Loss of weight
- ☐ ☐ ☐ Nervousness, depression
- ☐ ☐ ☐ Neuralgia
- ☐ ☐ ☐ Night terrors
- ☐ ☐ ☐ Numbness
- ☐ ☐ ☐ Sweats
- ☐ ☐ ☐ Tremors

Cardiovascular

- ☐ ☐ ☐ High blood pressure
- ☐ ☐ ☐ Low blood pressure
- ☐ ☐ ☐ Pain over heart
- ☐ ☐ ☐ Poor circulation
- ☐ ☐ ☐ Rapid heartbeat
- ☐ ☐ ☐ Slow heartbeart
- ☐ ☐ ☐ Heart murmur

Genitourinary

- ☐ ☐ ☐ Bed-wetting
- ☐ ☐ ☐ Bladder infections
- ☐ ☐ ☐ Blood in urine
- ☐ ☐ ☐ Frequent urination
- ☐ ☐ ☐ Kidney infection
- ☐ ☐ ☐ Painful urination
- ☐ ☐ ☐ Pus in urine

O F C

Eye, Ear, Nose and Throat

- ☐ ☐ ☐ Asthma
- ☐ ☐ ☐ Colds
- ☐ ☐ ☐ Circles under eyes
- ☐ ☐ ☐ Crossed eyes
- ☐ ☐ ☐ Deafness
- ☐ ☐ ☐ Dental decay
- ☐ ☐ ☐ Earache
- ☐ ☐ ☐ Ear discharge
- ☐ ☐ ☐ Ear noise
- ☐ ☐ ☐ Enlarged glands
- ☐ ☐ ☐ Enlarged thyroid
- ☐ ☐ ☐ Eye pain
- ☐ ☐ ☐ Failing vision
- ☐ ☐ ☐ Far sightedness
- ☐ ☐ ☐ Gum trouble
- ☐ ☐ ☐ Hay fever
- ☐ ☐ ☐ Hoarseness
- ☐ ☐ ☐ Nasal obstruction
- ☐ ☐ ☐ Near sightedness
- ☐ ☐ ☐ Nose bleeds
- ☐ ☐ ☐ Sinus infection
- ☐ ☐ ☐ Sore throat
- ☐ ☐ ☐ Tonsillitis

Gastrointestinal

- ☐ ☐ ☐ Belching or gas
- ☐ ☐ ☐ Colitis
- ☐ ☐ ☐ Colon trouble
- ☐ ☐ ☐ Constipation
- ☐ ☐ ☐ Diarrhea
- ☐ ☐ ☐ Difficult digestion
- ☐ ☐ ☐ Bloated abdomen
- ☐ ☐ ☐ Excessive hunger
- ☐ ☐ ☐ Jaundice
- ☐ ☐ ☐ Liver trouble
- ☐ ☐ ☐ Nausea
- ☐ ☐ ☐ Pain over stomach
- ☐ ☐ ☐ Poor appetite
- ☐ ☐ ☐ Vomiting
- ☐ ☐ ☐ Vomiting of blood

O F C

Skin

- ☐ ☐ ☐ Boils
- ☐ ☐ ☐ Bruise easily
- ☐ ☐ ☐ Dryness
- ☐ ☐ ☐ Hives or allergy
- ☐ ☐ ☐ Itching
- ☐ ☐ ☐ Psoriasis
- ☐ ☐ ☐ Skin eruptions (rash)

Pain or numbness in

- ☐ ☐ ☐ Shoulders
- ☐ ☐ ☐ Arms
- ☐ ☐ ☐ Elbows
- ☐ ☐ ☐ Hand
- ☐ ☐ ☐ Hips
- ☐ ☐ ☐ Legs
- ☐ ☐ ☐ Knees
- ☐ ☐ ☐ Feet
- ☐ ☐ ☐ Painful tailbone
- ☐ ☐ ☐ Poor posture
- ☐ ☐ ☐ Sciatica
- ☐ ☐ ☐ Spinal curvature
- ☐ ☐ ☐ Swollen joints

Respiratory

- ☐ ☐ ☐ Chest pain
- ☐ ☐ ☐ Chronic cough
- ☐ ☐ ☐ Difficult breathing
- ☐ ☐ ☐ Spitting up blood
- ☐ ☐ ☐ Spitting up phlegm
- ☐ ☐ ☐ Wheezing

Girls only

- ☐ ☐ ☐ Congested breasts
- ☐ ☐ ☐ Cramps or backache
- ☐ ☐ ☐ Excess menstrual flow
- ☐ ☐ ☐ Irregular cycle
- ☐ ☐ ☐ Lumps in breast
- ☐ ☐ ☐ Painful menstruation
- ☐ ☐ ☐ Vaginal discharge

Has your daughter started Menses? Y N
How old was she when she had Her first period?_____

Check any of the following conditions your child currently has or has had:

- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Cancer
- ☐ Chicken pox
- ☐ Cholera
- ☐ Cold sores
- ☐ Diabetes
- ☐ Eczema
- ☐ Edema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fever blisters
- ☐ Goiter
- ☐ Heart disease
- ☐ Herpes
- ☐ Influenza
- ☐ Lumbago
- ☐ Malaria
- ☐ Measles
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Pleurisy
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic fever
- ☐ Roseola
- ☐ Scarlet fever
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal disease
- ☐ Whooping cough