

Pediatric Patient History Form

Welcome to Rubin Family Chiropractic!

Please take a moment to fill out this form and sign the bottom.

Thanks! We will take GREAT care of you here!

Child's Name _____ Parent's Name _____
Last First MI Last First MI

Date of Birth _____ Age _____ Parent's Name _____
Last First MI

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Number _____ Cell Provider _____ Work Phone _____

SSN _____ Gender: M F Non-specified Birth Weight _____ Current Weight _____

Email _____ @ _____ Who referred you to our office? _____

Type of Birth: Vaginal _____ Forceps _____ Breech _____

Home _____ Hospital _____ Cesarean _____ Birthing center _____ other _____

Problem during pregnancy? _____

Problem with labor/delivery? _____

APGAR Scores: _____ And _____ Present at Birth? Jaundice (yellow) _____ Cyanosis (blue) _____

Congenital Anomalies? Genetic syndromes? _____

Infant Feeding: Breast _____ Bottle _____ Formula _____

Quality of Sleep: Good _____ Fair _____ Poor _____

Immunization History _____

Any childhood diseases? _____

Purpose of Last Visit to MD _____ Date _____

Purpose of This Appointment _____

Development History: At what age did the child...? Please indicate any difficulties or delays with each step

Smile:	Hold head up:	Roll:	Falls during 1 st year:	Hold object with hands:
Crawl:	Sit alone:	Talk:	Stand:	Walk alone:

Has this child ever suffered from: (circle all that apply)

Dizziness	Behavioral problems	Arm problems	"Growing pains"
Diabetes	Backaches	Ruptures/hernias	Stomachaches
Anemia	Headaches	Blood disorders	Chronic earaches
Poor appetite	Digestive disorders	Heart troubles	Cold/Flu
Bed wetting	Rheumatic fever	Diabetes/hypoglycemia	Allergies
Fainting	Hyperactivity	Paralysis	Constipation
Neck problems	Seizures	Broken bones	Diarrhea
Joint problems	Walking problems	Leg problems	Asthma

*Any other: _____

Surgery _____

Medications _____

Accidents _____

Family History _____

Has your child ever been treated on emergency basis: Y or N If so, why? _____

Consent to Treat Minor

I hereby authorize **Dr. Drew Rubin + RFC** and whomever he may designate as his assistants to administer treatment, as he deems necessary to my child _____.

Dated _____ day of _____ 20_____.

Signed _____.

I agree to assume responsibility for any charges created by the chiropractic and additional care, and give consent for my child to be examined and/or treated by Dr. Rubin, his staff, and interns.

Parental Signature _____ Date _____