CLOUD PEAK CHIROPRACTIC, P.C.

1511 Charles Avenue
Worland, WY 82401

Phone (307) 347-3500
Toll Free (877) 204-6731
Fax (307) 347-4893

Pediatric Patient Information Form

Full Name _____Likes to be called_____ Date _____
Birthdate _____ Age _____ Gender _____
Mailing Address _____
City/State/Zip _____
Phone _____

Patient's Mother or Guardian_____
Address (□ same as above)_____
Phone (□ same as above) _____
Email Address: _____
Occupation _____

Patient's Father or Guardian_____
Address (□ same as above)_____
Phone (□ same as above) _____
Email Address: (□ same as above)_____
Occupation _____

Siblings
Name _____ Age _____ Gender _____
Name _____ Age _____ Gender _____
Name _____ Age _____ Gender _____
Name _____ Age _____ Gender _____

Whom may we thank for referring you? _____

What is the reason for your visit? _____
_____
List any past illnesses/diseases: _____
_____
List any accidents/injuries/broken bones: _____
_____
List all medications and vitamins currently or has recently taken: _____
_____
Has child received vaccinations? _____
Please list sports or activities participated in, current and past:_____
_____
Number of hours child sleeps: _____ Sleep quality? □ Good □ Fair □ Poor
Any concerns about child's eating habits? _____
_____
Any concerns about child's development? _____
_____
Any concerns about the child's attitude? _____
_____
Is the child around anyone who smokes? _____

Child's Health History:

	Past	Present		Past	Present
Headaches	☐	☐	Diarrhea	☐	☐
Ear Problems	☐	☐	Constipation	☐	☐
Sleeping Disorder	☐	☐	Digestive Problems	☐	☐
Breathing Problems	☐	☐	Acid reflux	☐	☐
Fatigue	☐	☐	Colic	☐	☐
Irritability	☐	☐	Rashes	☐	☐
Hyperactivity	☐	☐	Allergies	☐	☐
Frequent Colds	☐	☐	Milk/Lactose Intolerance	☐	☐
Bloody Noses	☐	☐	Bedwetting	☐	☐
Meningitis	☐	☐	Scoliosis	☐	☐
			Learning Disability	☐	☐

Family Medical History: Please check anything that applies to the patient's siblings, parents, or grandparents:

- ☐ Allergy/Asthma/Eczema
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ Autoimmune Disease
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Illness
- ☐ Scoliosis

If patient is under age 5, please complete the following:

Pregnancy: Please check anything that applied to the patient's mother during her pregnancy:

- ☐ Prenatal Vitamins
- ☐ Medications
- ☐ Back Pain
- ☐ Other Pain
- ☐ Chiropractic Care
- ☐ Bed Rest
- ☐ Abnormal Weight Gain
- ☐ Smoking
- ☐ Recreational drugs
- ☐ Alcohol
- ☐ Physical Injury

Any pregnancy complications at all: _____
_____

Birth: Please check all that applied

- ☐ Hospital birth
- ☐ Home birth
- ☐ Caesarean
- ☐ Vacuum
- ☐ Forceps
- ☐ Labor was induced

How long was hard labor? _____
How long was the pushing phase? _____
Born at _____ weeks gestation
Birth Weight: _____ Length: _____

Any birth complications at all: _____
_____
List any problems the patient had at birth: _____
_____

Consent Form

I hereby request and authorize the doctors at Cloud Peak Chiropractic, P.C., to administer chiropractic care as he/she deems necessary to my dependent minor child. This authorization also extends to include diagnostic imaging, laboratory and other testing at the doctor's discretion. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to my child are charged directly to me and that I am personally responsible for payment at the time services are rendered.

Child's Name: _____

Your Relationship to Child: _____

As of today's date, I have the legal right to select and authorize health care service for the minor child named above.

If applicable, under the terms and conditions of my divorce, separation, or other legal authorization, the consent of a spouse, former spouse, or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

Today's Date: _____

Signature Parent/Guardian: _____

Please Print Name: _____

Address: _____

City/State: _____

Phone: _____

Witness: _____