Panzica Family Chiropractic Center **Pediatric Patient Health Assessment**

Please PRINT or WRITE Clearly

General Information

Child Name: _____ Parent Name: _____ Date:_____

Provider Name: Dr. Anthony J. Panzica _____ Primary Care Physician:_____

Child Soc. Sec. #: _____ Referred for Treatment by_____

Patient Address:_____ City:_____ State:_____ Zip:_____

Patient Sex: M_____F_____ Date of Birth: ___/___/___

Home Phone:_____ Parent Work Phone: _____

Cell Phone:_____ Email Address:_____

Subscriber Name:_____ Subscriber Social Security #: _____

Health Insurance Plan: _____ ID#: _____ Group #: _____

Who is responsible for this bill? ☐Parent ☐Guardian ☐Other

Has child had previous chiropractic care? Yes____ No____ When & where?_____

How were you referred to this office? _____

History

1. Describe purpose for this visit: _____

_____

_____

2. Prenatal and Birth History:

Birth Place: ☐Home ☐Hospital ☐Birth Center

Type of Birth: ☐Vaginal ☐C-section (planned) ☐C-section (emergency)

Procedures: ☐Forceps ☐Vacuum Extraction ☐Epidural ☐Natural ☐Waterbirth

Medications during pregnancy? Yes____ No____ Medications during labor/delivery? Yes____ No____

Was delivery induced? Yes____ No____

Was child at any time during pregnancy in the following position? ☐Breech ☐Transverse (side lying) ☐ Face/Brow Presentation

Child's Height and Weight at birth: _____ lbs. /oz. _____inches

Delivery Complications (if any): _____

_____

Feeding History:

Breast fed: Yes____ No____ Formula fed: Yes____ No____

Introduced to solids at age _____ Food Allergies or Sensitivities: _____

Vitamins or Supplements: _____

3. **Development::**

Did child reach developmental milestones such as crawling, walking and talking at appropriate ages? Yes____ No____

Has child ever fallen from a high place (bed, sofa, changing table, stairs, etc.)? Yes____ No____

Has child ever been involved in a motor vehicle accident? Yes____ No____

Does child have any learning challenges? Yes____ No____

Has child ever had surgery? Yes____ No____ If yes, please explain: _____

Has child ever been seen by a doctor or hospital on an emergency basis? Yes____ No____ If yes, please explain: _____

_____

Other traumas: _____

Has child received vaccinations? Yes____ No____

Has child ever had a reaction of any kind to a vaccination? (fever, rash, sleeplessness, etc.) Yes____ No____

Childhood Illnesses (at what age):

☐Chicken Pox _____ ☐Whooping Cough _____ ☐Mumps _____ ☐Measles _____

☐Rubella _____ ☐Scarlet Fever _____ ☐Other _____

Is child currently taking medication? Yes____ No____ If yes, please explain: _____

_____

Has child taken any medications for an extended period of time in the past? Yes____ No____ If yes, please explain: _____

_____

Has child ever been involved in sports?

☐Soccer ☐Football ☐Gymnastics ☐Baseball ☐Hockey ☐Karate ☐Other: _____

4. **Please check any of the following conditions that are a current problem. Please underline any that were a problem in the past.**

MUSCLE & JOINT
- ☐Sore muscles
- ☐Sore joints
- ☐Growing pains
- ☐Muscle cramps
- ☐Back problems
- ☐Neck problems
- ☐Painful tailbone
- ☐Pain between shoulders
- ☐Spinal Curvature
- ☐Arthritis
- ☐Difficulty chewing/ clicking jaw
- ☐General stiffness
- ☐Walking problems
- ☐Feet turn in/out
- ☐Coordination problems
- ☐Headaches

GENERAL
- ☐Fatigue
- ☐Allergies
- ☐Difficulty sleeping
- ☐Dizziness
- ☐Fainting
- ☐Earaches
- ☐Nose bleeds
- ☐Sore throat
- ☐Asthma
- ☐Chronic Cough
- ☐Enlarged glands
- ☐Loss of weight
- ☐Poor/excessive appetite
- ☐Junk food
- ☐Nervousness
- ☐Depression/Confusion
- ☐Hyperactivity
- ☐Behavioral problems
- ☐Frequent colds/flu
- ☐Epilepsy
- ☐Rheumatic fever

ORGANS
- ☐Bedwetting
- ☐Constipation
- ☐Diarrhea
- ☐Anemia
- ☐Thyroid
- ☐Vomiting
- ☐Skin eruptions/eczema
- ☐Stomach aches
- ☐Hearing problems
- ☐Dental problems
- ☐Vision problems

SURGERY (provide date)
- ☐Appendix _____
- ☐Tonsils _____
- ☐Hernia _____
- ☐Tubes in ears _____
- ☐Other: _____

_____

_____

_____

Comments: _____
_____
_____
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CONSENT

I, _____ (parent/legal guardian), give my permission to Dr. Anthony Panzica to perform necessary diagnostic tests and to render the recommended treatments thereafter to my child.

I also consent to billing any services performed to my insurance company (if applicable) and authorize the release of any information requested in order to process these claims.

Signature _____ Date _____

If your child is experiencing pain, please indicate the area on the figure below: