



PEDIATRIC  
REGISTRATION & HISTORY

Child's Name: \_\_\_\_\_  
Last First Middle

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

1<sup>st</sup> Parent's Name: \_\_\_\_\_ Work Phone: \_\_\_\_\_

2<sup>nd</sup> Parent's Name: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Would you like our free monthly Wellness Newsletter by email?  Yes  No email: \_\_\_\_\_

Birth date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex  M  F No. 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 \_\_\_\_\_

No. hours sleep per night: \_\_\_\_\_ Quality of sleep:  Good  Fair  Poor Explain: \_\_\_\_\_

Obstetrician/Midwife: \_\_\_\_\_  
Name Location

Pediatrician: \_\_\_\_\_  
Name Location Phone

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? \_\_\_\_\_

**PERSONAL HEALTH HISTORY - Has this child ever suffered from:**

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

Surgeries: \_\_\_\_\_

Medications (name & purpose): \_\_\_\_\_

Allergies \_\_\_\_\_

**FAMILY HEALTH HISTORY**

Please place a check mark if someone in the child's immediate family has had the following. Please write how they are related to the child.

- |  |  |
|--|--|
| <input type="checkbox"/> Back Problems _____       | <input type="checkbox"/> Headaches _____               |
| <input type="checkbox"/> High blood pressure _____ | <input type="checkbox"/> Ulcer/Digestive Problem _____ |
| <input type="checkbox"/> Thyroid Disorder _____    | <input type="checkbox"/> Heart Disease _____           |
| <input type="checkbox"/> Stroke _____              | <input type="checkbox"/> Arthritis _____               |
| <input type="checkbox"/> Diabetes _____            | <input type="checkbox"/> Cancer _____                  |
| <input type="checkbox"/> Osteoporosis _____        | <input type="checkbox"/> Mental Illness _____          |

**WELLNESS PROFILE**

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

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> more energy                   | <input type="checkbox"/> better sleep                  | <input type="checkbox"/> freedom from pain         |
| <input type="checkbox"/> better concentration          | <input type="checkbox"/> easier breathing              | <input type="checkbox"/> more balanced posture     |
| <input type="checkbox"/> try quality vitamins          | <input type="checkbox"/> improve nutrition             | <input type="checkbox"/> improved coordination     |
| <input type="checkbox"/> reduce medications            | <input type="checkbox"/> improve overall health        | <input type="checkbox"/> better sports performance |
| <input type="checkbox"/> enhanced emotional well-being | <input type="checkbox"/> greater resistance to disease | <input type="checkbox"/> other _____               |



PEDIATRIC WELLNESS PROFILE

We are interested in other aspects of health – mind, body, and spirit. There may be seemingly insignificant events that are contributing to today’s picture of your child. Please answer these questions to the best of your ability.

Growth and Development

Was the infant alert and responsive within 12 hours of delivery? Yes / No
If no, explain:
At what age did the child: Respond to sound Follow an object
Hold up head Vocalize Sit Alone Teethe
Crawl Walk

Chemical Stressors

Age when child was:
introduced to cow’s milk?
Began solid foods? Type:
Introduced to juice?
Juice/food intolerances? Y N Explain:
During pregnancy, did the mother
smoke? Y N Unknown
drink alcohol? Y N Unknown
take supplements? Y N Unknown
Any pets at home? Y N Type:
Any smokers at home? Y N

Psychosocial Stressors

Any difficulties with location? Y N
Any problems with bonding? Y N
Any behavioral problems? Y N If yes, state onset, any triggers, etc
Average number of hours of television / week:
Approximate hours spent at play per day
Does your child play before school?

Traumatic Stressors

Any trauma during pregnancy? (falls, accidents) Y N
Any evidence of birth trauma (please circle): bruises, odd shaped head, stuck in birth canal,
fast or excessively long birth, respiratory depression, cord around neck, other
Any falls from crib, bed, changing tables? Y N
Sports played and age began
Weight of school backpack:

Very often, parents know their children better than any doctor. To you, does your child seem “normal” for their age? Y N If no, please explain in the space below:

Thank you for completing these forms.



**AUTHORIZATION TO CONSENT TO TREATMENT OF MINOR**

(I) (We), the undersigned parent(s) of \_\_\_\_\_, a minor, do hereby consent to Berlin Chiropractic Corporation to any X-ray examinations, physical examination, chiropractic diagnosis or treatment, or physiological therapeutics which are deemed advisable by one of our chiropractic physicians.

These authorizations shall remain effective until \_\_\_\_\_, 20\_\_\_\_, unless sooner revoked in writing delivered to said agent(s).

\_\_\_\_\_  
Date of Signature

Signed: \_\_\_\_\_  
Parent/Guardian