Dr. Jamie Culhane

The chiropractor for expectant mothers, children and athletes.

PEDIATRIC PATIENT INTRODUCTION

Dear New Patient,
It is a pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To help us serve you better, please complete the following information. We look forward to working with our to build better health for your family.

CHILD'S NAME: ____
Last First Middle
MOTHER'S NAME: ____
Last First Middle
ADDRESS:____
CITY:______________STATE:_____ZIP:___________ Home #:____________________
Cell #: _________________________ Work #: __________________________
MOTHER'S DATE OF BIRTH:________________ SOC. SEC.# ____________________
MOTHER'S OCCUPATION:____

FATHER'S NAME: ____
Last First Middle
ADDRESS:__________________________CITY:___________ STATE:_____ZIP:______
FATHER'S DATE OF BIRTH:_______________ SOC. SEC.# _______________________
HOME PHONE: ____________________WORK PHONE: ________________________
FATHER'S OCCUPATION: ____

CHILD'S BIRTH DATE: ______________AGE:_____________SEX: _______________
PROBLEMS DURING PREGNANCY:____
____
WAS THERE PRESENCE AT BIRTH OF: _____ JAUNDICE (Yellow) ______ CYANOSIS (Blue)
INFANT FEEDING: BREAST __________ BOTTLE ___________ FORMULA __________
NO. OF HOURS SLEEP PER NIGHT:______ QUALITY OF SLEEP: GOOD____FAIR____POOR___
PEDIATRICIAN/FAMILY M.D.: ____
Name Located at
DATE OF LAST VISIT TO
PEDIATRICIAN:____________________PURPOSE:___________________________
PURPOSE OF THIS APPOINTMENT: ____
HAS YOUR CHILD BEEN TREATED ON AN EMERGENCY BASIS?: __________________
DESCRIBE: ____
NO. OF SIBLING: BROTHERS ____________________SISTERS____________________

PEDIATRIC CASE HISTORY

PREGNANCY HISTORY:

1ST TRIMESTER	2ND TRIMESTER	3RD TRIMESTER

____
____
____

Dr. Jamie Culhane
The chiropractor for expectant mothers, children and athletes.

PRENATAL HISTORY:
Please circle any area that applies to the <u>patient's mother</u> during her pregnancy:

Complications	Vaccination	Vitamins/Mineral
Medications:	Bleeding	Any Diagnosed Illnesses
Prescribed	Premature Contractions	Hospitalization
Over the Counter	Back Pain	Prenatal Care
Fertility Drugs	Other Pain	Carried to Full Term
Recreational Drugs	Excessive Decrease in Weight	Attitude – Happy (majority of time)
Smoked	Excessive Increase in Weight	Attitude – Depressed
Alcohol	Toxic Exposures	Ultra Sounds - # ________
Caffeine: Cola	Allergic Reactions	Antibiotics
Caffeine: Coffee	Mental Trauma	Amniocentesis
Caffeine: Tea	Physical Injury/Accidents	Chorionic Villi Sampling
Caffeine: Chocolate	Prenatal Classes	
Caffeine: Other	Chiropractic Care	

The duration of the pregnancy was ___________weeks.

LABOR & DELIVERY (Please circle which applies to you):

Greater than 12 hrs.	Fetal Monitor Used	Premature Delivery
Greater than 36 hrs.	Medications	Epidural

Complications during delivery: Yes___ No___. Please explain____________________________________
____
Genetic disorders/disabilities or congenital anomalies/defects : Yes___ No___. Please explain __________
____
Apgar Scores: ________, ________.
Birth Weight: _______________ Birth Length: _______________

TYPE OF BIRTH:

Normal Vaginal	Forceps	Breech	Cesarean	Vacuum Extraction
Home		Birthing Center		Hospital

Other:____(Please explain)
Was the birth traumatic? (i.e.: pulling, twisting) ____
Name of OB/Gyn:______________________________Name of Midwife:___________________________
Location: _____________________________________Location: __________________________________

<u>Please circle any problems the patient had at birth</u>.

Breathing	Nursing
Coloring	Sleeping
Crying	Jaundice
Choking	Other:____

<u>Please circle if any item(s) apply to the patient at birth</u>:

Medication	Silver Nitrate
Surgery	Vitamin K
Artificial Feeding	Circumcision

Other: ____

NUTRITIONAL HISTORY:
<u>Please circle if the patient has received any of the following items:</u>

Breast Milk – How long? _________	Sweets
Commercial Formula – Type? _________	Juice: Fruit

Dr. Jamie Culhane

The chiropractor for expectant mothers, children and athletes.

How Long?__________
Cow's Milk
Other Milk
Introduced to Solid Foods at__________months.
Food/Juice Allegies or Intolerances: ____

Juice: Vegetable
Vitamins
Medications

VACCINATIONS:
Please check any vaccinations the patient has received along with the date it was received and any reactions observed:

2 months: Polio #1 _________
DPT#1 _________
Hib Meningitis #1 ________
Hepatitis B #1 _________

4 months: Polio #2 _________
DPT #2 _________
Hib Meningitis #2 ________
Hepatitis B #2 _________

6 months: Polio #3 _________
DPT #3 _________
Hib Meningitis ________

12/15 months: MMR #1_________
Hib Meningitis __________
Hepatitis B #3 __________

15 months: DPT #4 __________

School Boosters: MMR #2__________

Before Kindergarten Entry: Polio #4 __________
DTP #5

Note foreign travel:____

Were you adequately informed of the risks of artificially vaccinating your child? Yes ___ No___

Did your child experience any behavioral, emotional or physical changes after any vaccination? Yes___ No___. Please describe ____

Please list any prediagnosed conditions or serious illnesses. Include any serious mental or physical traumas.____
____
____

GENERAL SYSTEM REVIEW:
Has you child ever been unconscious or had a convulsion? _____________________________________
____
Any problems with the eyes, including vision? ____
____
Any problems with speech?____
Has your child ever been cyanotic? (turned blue) Does s/he tolerate exercise? _____________________
____
Any recurring problem with vomiting, diarrhea, constipation, or stomach pain? ____________________
____
Do the stools look or smell abnormal?____
Any unusual problem on passing urine or any unusual frequency? Any unusual smell or appearance of urine?____
Does your child complain of any arm, leg or back pain? Do you notice a limp or unusual gait pattern?
____
Any skin, hair, nail, tooth problems?____

Dr. Jamie Culhane

The chiropractor for expectant mothers, children and athletes.

Any allergies, eczema, hay fever, hives, asthma, or drug reactions?_______________________________
____

Other problems?____
____
____

DEVELOPMENTAL HISTORY: During the following times your child's spine is most vulnerable to stress and should routinely be checked by a Doctor of Chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference).

At what age was your child able to:

Respond to sound_______________________________ Crawl _____________________________

Follow an object with eyes________________________ Stand_______________________________

Hold head up___________________________________ Walk alone__________________________

Sit alone___________________________

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e., a bed, changing table, down stairs, etc.). Was this the case with your child? Yes___ No___ Please explain:____

Is/has your child been involved in any high impact or contact type of sports (i.e., Soccer, Football, Gymnastics, Baseball, Cheerleading, Martial Arts, etc.)? Yes ___ No___ List: ______________________
____

CHILDHOOD DISEASES:

Chickenpox Yes ___ No ___ Age ____ Rubella Yes ___ No ___ Age____

Mumps Yes ___ No ___ Age ____ Measles Yes ___ No ___ Age ____

Whooping Cough Yes ___ No ___ Age____

Other: ____

HAS THIS CHILD EVER SUFFERED FROM: (Please circle those that apply)

Ear Infections	Headaches	Tuberculosis	Paralysis
Asthma/Allergies	Growing/Back Pains	Rheumatic Fever	Broken Bones
Colic	Dizziness	Hyperactivity	Leg Problems
Scoliosis	Diabetes	Convulsions	Constipation
Digestive Problems	Arthritis	Walking Problems	Diarrhea
Bed Wetting	Neuritis	Arm Problems	Behavioral Problems
Seizures	Anemia	Heart Trouble	Muscle Jerking
ADHD	Poor Appetite	Hypertension	Ruptures/Hernias
Chronic Colds	Fainting	Sinus Trouble	Auto Accident
Recurring Fevers	Neck Problems	Orthopedic Problems	Sporting Injuries
Temper Tantrums	Joint Problems	Sugar Concentration	

Has your child ever been involved in a car accident? Yes ___ No ___ List:_________________________
____

PRESENT HISTORY:____
____
____

Surgery:____

Medications:____

Dr. Jamie Culhane

The chiropractor for expectant mothers, children and athletes.

Accidents:____

Family History:____

AUTHORIZATION FOR CARE OF MINOR

I HEREBY AUTHORIZE THIS CLINIC AND IT'S DOCTOR(S), DR. JAMIE M. CULHANE TO ADMINISTER CARE AS SHE DEEMS NECESSARY TO MY SON/DAUGHTER/WARD.

____
(Name of Son/Daughter)

SIGNED: _________________________WITNESSED: _____________________DATE:____________

I REALIZE THAT I AM RESPONSIBLE FOR ALL FEES CHARGED BY THIS CLINIC AND THAT I WILL PAY FOR ALL SERVICES AS THEY ARE PERFORMED. X-RAYS REMAIN THE PROPERTY OF THE CLINIC.

DATE: _________________ SIGNATURE: ____