GLOBAL WELLNESS CLINIC, P.C.

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PEDIATRIC PATIENT INTRODUCTION (5 & under)

CHILD'S NAME _____ MOTHER'S NAME_____
LAST FIRST MIDDLE LAST FIRST MIDDLE

CASE NUMBER: _____ FATHER'S NAME _____
LAST FIRST MIDDLE

ADDRESS: _____ CITY/TOWN: _____ STATE: _____ ZIP _____

HOME PHONE: _____ MOTHER'S WORK PHONE: _____ FATHER'S WORK PHONE: _____

BIRTH DATE: ____ ____ ____ AGE: _____ BIRTH WEIGHT: _____ CURRENT WEIGHT: _____

SEX: _____ NO. OF SIBLINGS: _____ BIRTH LENGTH: _____ CURRENT LENGTH: _____

TYPE OF BIRTH: NORMAL VAGINAL _____ FORECEPS _____ BREECH _____ CESAREAN _____

HOME: _____ BIRTHING CENTER _____ HOSPITAL _____

PROBLEMS DURING
PREGNANCY (History):_____

PROBLEMS DURING
LABOR/DELIVERY (History):_____

APGAR SCORES: _____ ____ AT BIRTH WAS THERE PRESENSE OF: ____ JAUNDICE (YELLOW)
____ CYANOSIS (BLUE)

CONGENITAL ANOMALIES/DEFECTS: _____

INFANT FEEDING: BREAST _____ BOTTLE _____ FORMULA _____

NO. OF HOURS SLEEP PER NIGHT: _____ QUALITY OF SLEEP: GOOD ____ FAIR ____ POOR ____

DEVELOPMENTAL HISTORY: AT WHAT AGE DID THE CHILD:

_____ Respond to sound
_____ Follow an object with his/her eyes
_____ Hold head up
_____ Sit alone
_____ Crawl
_____ Stand
_____ Walk alone

CHILDHOOD DISEASES: _____ CHICKENPOX _____ RUBELLA
_____ MUMPS _____ RUBEOLA
_____ MEASLES _____ WHOOPING COUGH

OTHER: _____

Previous Chiropractor _____

Pediatrician/ Family Medical Doctor _____

DATE OF LAST VISIT TO MD: _____ PURPOSE: _____

Has your child ever been treated on an emergency basis? _____

DESCRIBE: _____

OVER ➔

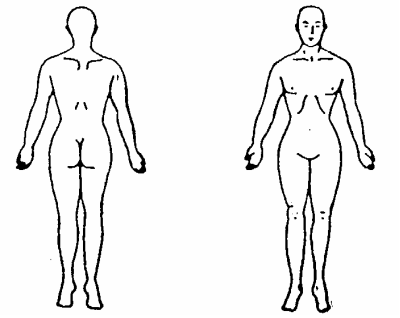
Global Wellness Clinic's objective is different from an Allopathic's (M.D./D.O.) objective. Our objective is not to just treat a condition, rather identify and correct subluxations.

If you have no condition and are seeking chiropractic care to optimize body function, skip to Section II.

Section I (If applicable)

Present complaint (brief) _____
Date started _____
Do you know what may have started it? _____
What aggravates condition/pain? _____
What lessens condition/pain? _____
Is condition worse during certain times of day? _____
Is condition interfering with work? _____
Is condition getting progressively better, worse, no change? _____
Has this problem interrupted your sleep ☐ Yes ☐ No How?_____
Have you seen a doctor for this condition? _____ When? _____
What tests did you have? _____
What diagnosis did they give? _____
What treatment did you receive? _____

Rate your condition by circling number (0 1 2 3 4 5 6 7 8 9 10) (If applicable)
(none----------worse)



← Locate exact point of pain on picture.

Is the pain Sharp _____ Dull _____ Constant _____ Off & On _____

Section II (If applicable)

Do you drink pop? _____
Past auto accidents? _____
Injuries? _____
Fractures (broken bones)? _____
Teeth, eyes, or hearing problems? _____
Surgeries (Please list all) _____
Current medications _____
Allergies _____

Family History	Heart	Arthritis	Cancer	Diabetes	Other
Father	_____	_____	_____	_____	_____
Mother	_____	_____	_____	_____	_____

To the best of my knowledge, all statements in the above Health history are true.

Signed _____ Date _____
(If patient is under 18 years, parent must sign)