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Please fill out as much as possible of your contact information and child's medical history. Read and sign the HIPPA agreement. You can bring them with you to your initial appointment, or fax or mail them back to us beforehand if you prefer. Thanks!

Registration Information

Please Print

Date: _____
Child's Name:_____
Parent's Name(s):_____
Address:_____
City: _____Zip Code:_____
Birth Date:_____Sex:_____
Emergency Contact including Phone Number:_____

Indicate best number to reach you for confirmations or cancellations:
☐Cell:_____ ☐Home tel:_____
☐Work Phone:_____

Email:_____

Which do you prefer for appointment confirmations: ☐ text or ☐ voice message?

Pediatric Questionnaire *(PLEASE ANSWER AS much AS POSSIBLE)*

Parents' Names:_____Today's Date:_____

Child's Name:_____ Age:_____ Birthdate:_____

Reason for Visit: _____

Medications: _____

Allergies to medications: _____

Surgeries: _____

Traumas/Accidents/Injuries:_____

_____

Dental Work/Braces:_____

Illnesses/Hospitalizations:_____

_____

Mother's age at delivery _____ Baby's age at delivery (in weeks)___ _____

Number of older siblings _____ Number of younger siblings _____ Pregnancy planned: *Yes No*

Medicines/caffeine/tobacco/alcohol used during pregnancy: _____

Delivery: Hours of Labor _____

Time Pushing: _____Medicines used during labor: _____

Epidural: *Yes No* Pitocin augmentation: *Yes No* Forceps: *Yes No* Vacuum: *Yes No*

C-section: *Yes No* Reason: _____

Presentation: Vertex (Head)_____Breech (Feet)_____Transverse (Side) _____

APGAR_____ First Cry: *strong weak* Weight _____Head Circumference _____Length ____

Complications Mom: _____

Complications Baby:_____

Immediately to breast? *Yes No* *Breast* or *Bottle* Strong suck: *Yes No* Spit-up: *Yes No*

Vomit: *Yes No* Failure to thrive: *Yes No* Formula(s) _____ *Yes No*

Colic: *Yes No* Sleep well: *Yes No* Age first slept through the night_____

Start solids: *Yes No* When?_____ Able to feed self: *Yes No*

Was baby placed on belly as infant? *Yes No*

Personality:_____

Typical Diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Food intolerancies/allergies: _____

Water intake (glasses per day) _____Supplements:_____

Milestone	Age Completed	Milestone	Age completed
Smile		Sit w/support	
Coo		Crawl/creep	
Reach For		Cruise	
Babble		Walk	
First Word		Climb stairs	
2-4 Words		Climb Stairs alternate feet	
Toilet train		Feed self	

School Issues/Concerns: _____

Interests/Hobbies: _____

Medical Problems in Family:_____

_____

Pediatrician:_____

Other Osteopath, Homeopath or Specialists/Therapies: _____

_____

_____

Other Pertinent Information or Concerns: _____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare providers to perform the necessary health care services my child may need, including Osteopathic Manipulation.

Signature_____Date_____