PEDIATRIC PATIENT INTRODUCTION CARD

Date:_____

Child's Name:_____Age:_____Date of Birth:_____Sex: M F

Street Address:_____City, ST, Zip:_____

Parent's Names:_____

Phone:_____Email:_____

Whom may we thank for referring you to our office?_____

Reason for coming to our office:_____

Name of Person Responsible for the Account:_____

Relationship to Patient:_____Preferred Phone #:_____

Address (if different than above):_____

Insurance Company:_____Name of Insured:_____

Relationship to Patient:_____Date of Birth:_____

Present Health Challenge(s)

For what health challenge(s) is your child here for? When did it begin?

_____

Has your child seen other health care practitioners for this? What did they recommend?

_____

What was the outcome of prior treatment/recommendations?

_____

Is this dysfunction getting progressively worse? ___Yes ___No

Health History

Symptoms: Please check any current or past problems your child has on the list below:

__Anemia
__Arthritis
__ADHD
__Allergies
__Anxiety
__Arm/Elbow Pain
__Asthma
__Autism
__Backaches
__Behavioral Issues
__Bed Wetting
__Blood disorders
__Broken bones:_____
__Chest Pain
__Chronic Earaches
__Colic
__Concussions
__Constipation
__Convulsions
__Cough/Wheeze
__Diabetes
__Diarrhea
__Digestive Problems
__Dizziness
__Eczema
__Fainting
__Fever/Chills
__Frequent Colds
__Growing pains
__Headaches
__Heart Condition
__Hernias
__Hyperactivity
__Hypertension
__Joint Pain
__Insomnia
__Itchy Eyes
__Knee/Foot Pain
__Leg/Hip Pain
__Muscle Pain
__Neck Pain
__Nightmares
__Poor Appetite
__Poor Memory
__Rashes
__Reflux/Spitting up
__Runny Nose
__Scoliosis
__Sinus Trouble
__Sprains/Strains
__Stomach Aches
__Unusual Moles
__Other_____