

The Marino Center for Integrative Health

Chiropractic Pediatric Form

Date _____

Child's Name _____ Birthdate _____

Height _____ Weight _____ Boy / Girl _____

Address _____

Mother's Name _____ Father's Name _____

Home Phone _____ Work Phone _____

Cell Phone _____ Email _____

How did you hear about our office? _____

Previous Chiropractic care? Yes / No; If yes then whom _____

Reason for your child's visit _____

Other health care providers seen for this condition Yes / No If yes, please list below with addresses

Name of Pediatrician and location _____

Childs Health History

Any other current or previous health problems? _____

Ear infections Asthma Allergies Colic Digestive issues
 Chronic Colds Fevers Bed wetting Tantrums Headaches

Accidents/Injuries (such as falls from a bed/changing table, car accidents, sports)

Sleep Patterns: Quality of sleep: Good - Fair- Poor; Hours per night _____
Hours per nap _____ Number of naps/day _____

Breast fed: Yes/No If yes, how long _____

Bottle fed: Yes/No If yes, when started and for how long _____

Cows milk: Yes / No Soy milk: Yes / No Rice milk: Yes / No

Frequency of feedings _____

Introduction of solid foods/ what type _____

Any known food allergies or intolerances Yes / No _____

Overall mood of your child: ex. Happy, excessive crying, calm...

Child's Name: _____

Current medications/supplements

Previous Antibiotic use: Yes / No, if yes what type, when and duration of prescription

Child's reaction to the medication, ex. diarrhea, vomiting... _____

Vaccination History: Please indicate the number of doses received and approximately when they were administered

Hepatitis B _____ DTaP _____

HiB _____ Pneumococcal _____

Polio _____ Influenza _____

MMR _____ Varicella _____

Hepatitis A _____

Any adverse reactions? Yes / No, If yes _____

Pregnancy/Labor/Delivery

Name of Obstetrician or midwife and birth center _____

Complications during pregnancy: Yes / No, If yes: _____

Injuries/accidents during pregnancy: Yes / No, If yes _____

Therapy during pregnancy (Chiropractic, massage...) Yes/ No, If yes _____

Medications during pregnancy: Yes / No, If yes _____

Other health problems (diabetes, pre-eclampsia, bed rest) Yes / No, if yes _____

Smoking or alcohol use during pregnancy: Yes / No, If yes _____

Length of labor/delivery (pushing): _____

Medications used during labor: _____

Type of birth: ___ Vaginal ___ C-Section ___ Forceps ___ Vacuum extraction

If C-Section was it: ___ Emergency ___ Planned

Baby's birth weight and length: _____ APGAR Scores: _____

Problems after delivery: Yes / No, If yes _____

Length of stay: _____

Developmental History

At what age was your child able to perform the following:

Respond to Sound _____ Cross Crawl _____

Respond to Visual Stimuli _____ Stand Alone _____

Hold head up _____ Walk Alone _____

Sit up _____

Menarche (If applicable) _____

Authorization for care of a minor

I hereby authorize The Marino Center and its doctors to administer care as they deem necessary to my son/daughter/ward.

I accept responsibility for payment of services rendered.

Parent Name- printed

Parent Signature

Date: _____