



Rockwall Health Center  
2880 Ridge Rd  
Rockwall, TX 75032  
(469) 769-1009

## PEDIATRIC PATIENT HEALTH RECORD

CHILD'S NAME:	
MOTHER'S NAME:	DOB:
FATHER'S NAME:	DOB:
ADDRESS:	
CITY:	STATE/ZIP:
HOME PHONE:	EMAIL:
MOTHER'S WORK PHONE:	MOTHER'S CELL:
FATHER'S WORK PHONE:	FATHER'S CELL:

BIRTH DATE:	AGE:	SEX:
NUMBER OF SIBLINGS:	REFERRED BY:	
BIRTH WEIGHT:	BIRTH LENGTH:	
CURRENT WEIGHT:	CURRENT LENGTH:	

THIRD TRIMESTER PRESENTATION VERTEX:	BREECH:	TRANSVERSE:	FACE/BROW:
TYPE OF BIRTH NORMAL VAGINA:	FORCEPS:	CESAREAN:	SUCTION CAP OR VACUUM:
LOCATION HOME:	BIRTHING CENTER:	HOSPITAL:	
PROBLEMS DURING PREGNANCY:			
PROBLEMS DURING LABOR/DELIVERY:			
APGAR SCORES:	WAS THERE PRESENCE AT BIRTH OF JAUNDICE (YELLOW)?	CYANOSIS (BLUE)?	
CONGENITAL ANOMALIES/DEFECTS?	IF YES, PLEASE EXPLAIN:		

INFANT FEEDING-BREAST:	BOTTLE:
IF BOTTLE, WHICH FORMULA?	
NUMBER OF HOURS SLEEPING PER NIGHT:	
QUALITY OF SLEEP-GOOD:	FAIR: POOR:

OBSTETRICIAN/MIDWIFE:	
PEDIATRICIAN/FAMILY MD:	
DATE OF LAST VISIT:	PURPOSE:
IMMUNIZATION HISTORY:	
NUMBER OF DOSES OF ANTIBIOTICS YOUR CHILD HAS TAKEN- DURING THE PAST SIX MONTHS:	DURING HIS/HER LIFETIME:
PREVIOUS CHIROPRACTOR:	
DATE OF LAST VISIT:	PURPOSE:
HAS YOUR CHILD EVER BEEN TREATED ON AN EMERGENCY BASIS? IF YES, PLEASE EXPLAIN:	
PURPOSE OF THIS APPOINTMENT:	

DELIVERY/BIRTH HISTORY:
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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:
AT WHAT AGE, IF EVER, DID THIS CHILD SUFFER FROM THE FOLLOWING CHILDHOOD DISEASES?			
CHICKENPOX:	MUMPS:	MEASLES:	
RUBEOLA:	WHOOPING COUGH:	RUBELLA:	OTHER:

HAS THIS CHILD EVER SUFFERED FROM?

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> HEADACHES     | <input type="checkbox"/> ORTHOPEDIC PROBLEMS | <input type="checkbox"/> DIGESTIVE DISORDERS  |
| <input type="checkbox"/> DIZZINESS     | <input type="checkbox"/> BEHAVIORAL PROBLEMS | <input type="checkbox"/> NECK PROBLEMS        |
| <input type="checkbox"/> POOR APPETITE | <input type="checkbox"/> ADD/ADHD            | <input type="checkbox"/> FAINTING             |
| <input type="checkbox"/> ARM PROBLEMS  | <input type="checkbox"/> REFLUX              | <input type="checkbox"/> MUSCLE PAIN          |
| <input type="checkbox"/> STOMACH ACHES | <input type="checkbox"/> RUPTURES/HERNIA     | <input type="checkbox"/> SEIZURES/CONVULSIONS |
| <input type="checkbox"/> LEG PROBLEMS  | <input type="checkbox"/> HEART TROUBLE       | <input type="checkbox"/> JOINT PROBLEMS       |
| <input type="checkbox"/> CONSTIPATION  | <input type="checkbox"/> GROWING PAINS       | <input type="checkbox"/> CHRONIC EARACHES     |
| <input type="checkbox"/> BACKACHES     | <input type="checkbox"/> DIARRHEA            | <input type="checkbox"/> SINUS TROUBLE        |
| <input type="checkbox"/> POOR POSTURE  | <input type="checkbox"/> DIABETES            | <input type="checkbox"/> HYPERTENTION         |
| <input type="checkbox"/> SCOLIOSIS     | <input type="checkbox"/> ASTHMA              | <input type="checkbox"/> COLDS/FLU            |
| <input type="checkbox"/> COLIC         | <input type="checkbox"/> WALKING TROUBLE     | <input type="checkbox"/> ANEMIA               |
| <input type="checkbox"/> BROKEN BONES  | <input type="checkbox"/> BED WETTING         | <input type="checkbox"/> OTHER                |
| <input type="checkbox"/> ALLERGIES:    |  |   |

HAS THIS CHILD EVER SUFFERED THE FOLLOWING SPINAL TRAUMAS?

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> FALL IN BABY WALKER      | <input type="checkbox"/> FALL FROM BED/COUCH  | <input type="checkbox"/> FALL OFF SKATEBOARD/SKATE |
| <input type="checkbox"/> FALL FROM CRIB           | <input type="checkbox"/> FALL OFF SWING       | <input type="checkbox"/> FALL OFF BICYCLE          |
| <input type="checkbox"/> FALL FORM HIGHCHAIR      | <input type="checkbox"/> FALL OFF SLIDE       | <input type="checkbox"/> FALL DOWN STAIRS          |
| <input type="checkbox"/> FALL FROM CHANGING TABLE | <input type="checkbox"/> FALL OFF MONKEY BARS | <input type="checkbox"/> OTHER                     |

HAS THIS CHILD EVER SUSTAINED AN INJURY PLAYING ORGANIZED SPORTS?

- YES  NO

IF YES, PLEASE EXPLAIN:

HAS THIS CHILD EVER SUSTAINED INJURIES IN AN AUTO ACCIDENT?

- YES  NO

IF YES, PLEASE EXPLAIN:

PRESENT HISTORY:

SURGERY:

MEDICATIONS:

ACCIDENTS:

FAMILY HISTORY:

**AUTHORIZATION FOR CARE OF MINOR**

I HEREBY AUTHORIZE THIS OFFICE AND ITS DOCTOR(S) TO ADMINISTER CARE AS THEY DEEM NECESSARY TO MY SON/DAUGHTER. I REALIZE THAT I AM RESPONSIBLE FOR ALL FEES CHARGED BY THIS OFFICE AND I AGREE TO PAY FOR ALL SERVICES PROVIDED. X-RAYS REMAIN PROPERTY OF THIS OFFICE.

SIGNED: \_\_\_\_\_

DATE: \_\_\_\_\_