

Danita Thomas Heagy, DC, LLC

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Pediatric Form (Birth-18 yrs)

Date _____ Patient Name _____ Parent's Name _____
Phone _____ Address _____ City _____ State _____ Zip _____
Age _____ Birth Date _____ Height _____ Weight _____ # Siblings _____
Present family doctor _____ Address _____
Date of last visit to MD _____ Reason _____

Check the following conditions that your child has had and what kind of treatment was received:

Ear Infections	<input type="checkbox"/>	Digestive Problems	<input type="checkbox"/>	Chronic Colds	<input type="checkbox"/>	Headaches	<input type="checkbox"/>
Asthma/Allergies	<input type="checkbox"/>	Bed Wetting	<input type="checkbox"/>	Recurring Fevers	<input type="checkbox"/>	Growing/Back Pains	<input type="checkbox"/>
HIV/Aids	<input type="checkbox"/>	Drug Addiction	<input type="checkbox"/>	Colic	<input type="checkbox"/>	Seizures	<input type="checkbox"/>
Temper Tantrums	<input type="checkbox"/>	Car Accident	<input type="checkbox"/>	Scoliosis	<input type="checkbox"/>	ADHD	<input type="checkbox"/>
Chronic Fatigue	<input type="checkbox"/>	Other	_____				

Family History (cancer, diabetes, heart disease, etc.):

PREVIOUS CHIROPRACTIC CARE:

Yes ___ No ___ Date of last adjustment _____ Name of Chiropractor _____

Are you satisfied with the care that your child received there? Y ___ N ___ Explain: _____

Main objective in consulting our office _____

Any treatment, therapies or care for this issue (including drugs): _____

Date of onset _____ Check one: Sudden ___ Gradual ___

PRENATAL HISTORY:

Duration of gestation _____ weeks? Pregnancy normal? Yes ___ No ___ Tobacco/Alcohol use? Yes ___ No ___

List any significant complications during pregnancy: _____

Location of Birth: Hospital ___ Birthing Center ___ Home ___ Length of labor ___ hrs.

Drugs used during delivery? Yes ___ No ___

Birth Intervention: Forceps ___ Vacuum Extraction ___ C- Section ___ Was it an Emergency ___ or planned ___?

List any medications taken during pregnancy: _____

List any medication taken during delivery: _____

Apgar score at birth: ___ Apgar score at 5 min. ___ Birth Weight ___ Length ___

DEVELOPMENTAL HISTORY:

Were you alert and responsive within 12 hours of delivery? Yes ___ No ___ If NO, explain: _____

At what age did your child: Respond to sound _____ Follow an object with their eyes _____ Hold head _____
Sit Alone _____ Crawl _____ Stand _____ Walk alone _____

For Girls only: Is she menstruating yet? Yes ___ No ___ If yes, what age did she begin? _____

NUTRITIONAL HISTORY:

Breastfed ___ months Formula began at age ___ for ___ months. Type used: _____

Cow's milk began at age _____. Other milk _____ Began solid foods at _____ months

Were commercially prepared baby foods used? Yes ___ No ___ Type: _____

CHILDHOOD DISEASES:

Chickenpox Y N Age _____ Rubella Y N Age _____ Asthma Y N Age _____

Mumps Y N Age _____ Rubeola Y N Age _____ Allergies Y N Age _____

Measles Y N Age _____ Whooping Cough Y N Age _____

Other: _____

Vaccinations Yes ___ No ___. List vaccination type and age _____

TRAUMA:

According to the National Safety Council, approximately 50% of all children fall head first from a high place during their first year of life (i.e: a bed, changing table, down stairs, etc.) Was this the case with your child? ___

Is/has your child been involved in any high impact or contact type sports (i.e: soccer, football, gymnastics, baseball, cheerleading, martial Arts, etc.)? Yes ___ No ___ Please list _____

OSHEA (Occupational Safety & Health Administration) statistics report that by the age of seven the average child has been involved in 2,500 traumas. Please provide a list of your child's traumas (including emergency hospital visits, falls, fractures, car accidents, etc). Use the back of the page if necessary:

1. _____ When _____ 3. _____ When _____

2. _____ When _____ 4. _____ When _____

Has your child undergone any surgeries? Yes ___ No ___

Type _____ When _____

Type _____ When _____

List any medications you are currently taking:

1. What _____ When _____ 3. _____ When _____

2. What _____ When _____ 4. _____ When _____

AUTHORIZATION FOR CARE OF MINOR:

I hereby authorize Danita Thomas Heagy, DC to administer care as she deems necessary to my son/daughter.

Signature: _____ Date _____