

Family Chiropractic Center of Bayonne

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PEDIATRIC PATIENT INTRODUCTION

TO SAVE TIME AND ALLOW US TO BETTER SERVE YOU PLEASE COMPLETE ALL QUESTIONS

CHILD'S NAME: _____ MOTHER'S NAME: _____

SOCIAL SECURITY# _____ FATHER'S NAME: _____

PHONE NUMBER: _____

ADDRESS: _____

BIRTH DATE: _____ AGE: _____ BIRTH WEIGHT: _____ CURRENT WEIGHT: _____

TYPE OF BIRTH: NORMAL VAGINAL FORCEPS BREECH CESAREAN

HOME BIRTHING CENTER HOSPITAL APGAR SCORES: _____

WAS THERE PRESENCE AT BIRTH OF: JAUNDICE (YELLOW) CYANOSIS (BLUE)

PROBLEMS DURING PREGNANCY? _____

PROBLEMS DURING LABOR/DELIVERY? _____

CONGENITAL ANOMALIES/DEFECTS: _____

INFANT FEEDING: BREAST BOTTLE FORMULA

NUMBER OF HOURS SLEEP PER NIGHT: _____ QUALITY OF SLEEP: GOOD FAIR POOR

OBSTETRICIAN/MIDWIFE: _____
(NAME) (LOCATION)

PEDIATRICIAN/FAMILY MD _____
(NAME) (LOCATION)

DATE OF LAST VISIT TO MD: _____ PURPOSE OF VISIT _____

IMMUNIZATION HISTORY: _____

PURPOSE OF THIS APPOINTMENT: _____

HAS YOUR CHILD EVER BEEN TREATED ON AN EMERGENCY BASIS? YES (PLEASE DESCRIBE BELOW) NO

DESCRIBE _____

AUTHORIZATION FOR CARE OF MINOR

I HEREBY AUTHORIZE THIS CLINIC AND ITS DOCTOR (S) TO ADMINISTER CARE AS THEY SO DEEM NECESSARY TO MY SON/DAUGHTER/WARD (UPON APPROVAL OF PARENT OR GUARDIAN)

SIGNED _____ WITNESSED _____ DATE _____

I REALIZE THAT I AM RESPONSIBLE FOR ALL FEES CHARGED BY THIS CLINIC AND THAT I WILL PAY FOR ALL SERVICES AS THEY ARE PERFORMED.

DATE: _____ SIGNATURE: _____

PREGNANCY HISTORY: _____

DELIVERY / BIRTH HISTORY: _____

DEVELOPMENT HISTORY: AT WHAT AGE DID CHILD:

RESPOND TO SOUND: _____ FOLLOW OBJECTS WITH EYES: _____ HOLD HEAD UP: _____
SIT ALONE: _____ CRAWL: _____ STAND: _____ WALK ALONE: _____

CHILDHOOD DISEASES: CHICKENPOX: YES NO RUBELLA: YES NO

MUMPS: YES NO MEASELS: YES NO WHOOPING COUGH: YES NO

OTHER: YES NO

HAS THIS CHILD EVER SUFFERED FROM:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Chronic earaches | <input type="checkbox"/> "Growing Pains" | <input type="checkbox"/> Paralysis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Colds/Flu | <input type="checkbox"/> Headaches | <input type="checkbox"/> Poor appetite |
| <input type="checkbox"/> Arm problems | <input type="checkbox"/> Constipation | <input type="checkbox"/> Heart trouble | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Ruptures / Hernias |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Depression | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Sinus trouble |
| <input type="checkbox"/> Backaches | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Joint problems | <input type="checkbox"/> Stomach aches |
| <input type="checkbox"/> Bed wetting | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Leg problems | <input type="checkbox"/> Sugar concentration |
| <input type="checkbox"/> Behavioral problems | <input type="checkbox"/> Digestive disorders | <input type="checkbox"/> Neck problems | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Blood disorders | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Neuritis | <input type="checkbox"/> Walking problems |
| <input type="checkbox"/> Broken bones | <input type="checkbox"/> Fainting | <input type="checkbox"/> Orthopedic problems | <input type="checkbox"/> Other |

PRESENT HISTORY: _____

SURGERY: _____

MEDICATIONS: _____

ACCIDENTS: _____

FAMILY HISTORY: _____

