ANDERSON UPPER CERVICAL

1099 MERCHANTS DRIVE, SUITE A, DALLAS, GEORGIA 30132-3005
PHONE: 770-443-0787 ~ FAX: 770-443-3890 ~ EMAIL: info@andersonuc.com

CS#_____

Pediatric Information (Child age 10 & younger)

PEDIATRIC PATIENT CASE HISTORY

Patient's Name: _____ DOB_____ Sex: __M __ F

Reason for today's visit:

_____

Age:_____ Birth Weight: _____ Current Weight: _____ Birth Length: _____ Current Length: _____ # of Siblings: ____

PARENTAL CONTACT INFORMATION:

Mother's Name: _____ Father's Name _____

Address: _____ City: _____ State: _____

9 digit Zip:_____ - _____ Home Ph#:: _____

Contact Cell #:_____ ___Mothers' ___ Fathers'

Contact Email to use: _____ ___ Mothers' ___ Fathers'

Preferred Appt Reminder Method: ____ Text to cell # above _____ Email ____ Phone Call to cell # above ____ NONE

Obstetrician/Midwife:

_____

Name Location Phone # Date of Last Visit

Pediatrician/Family MD:

_____

Name Location Phone # Date of Last Visit

Congenital Anomalies/Defects of the Child:

_____

Family History of Congenital Anomalies/Defects:

_____

Type of Birth (circle all that apply): Vaginal Forceps Suction Breech Cesarean Cord around neck

Birthing Location: Home Birth Birthing Center:_____ Hospital: _____

Pregnancy History / Problems during Pregnancy:

_____

_____

ANDERSON UPPER CERVICAL

1099 MERCHANTS DRIVE, SUITE A, DALLAS, GEORGIA 30132-3005
PHONE: 770-443-0787 ~ FAX: 770-443-3890 ~ EMAIL: info@andersonuc.com

CS#_____

Delivery & Birth History / Problems during Labor & Delivery:

_____

_____

APGAR Scores: _____ _____ Was there presence at birth of: _____Jaundice (yellow) _____ Cyanosis (blue)

Infant Feeding: # of Months Breastfed: _____ # of Months Bottlefed Breast milk only: _____

# of Months Bottlefed Formula: _____ Brand(s): _____

Number of hours of sleep per night: _____ Quality of sleep (circle): Good Fair Poor

Immunization History:

_____

_____

Developmental History: At what age did the child:

_____Respond to sound	_____Sit unaided	_____Follow an object with eyes	_____Hold head up
_____Walk unaided	_____Crawl	_____Stand unaided	_____ Speak

Childhood Diseases & indicate age child was diagnosed with:

Chicken Pox _____ Mumps _____ Measles _____ Rubella _____ Whooping Cough_____

Other: _____

Has this child ever suffered from: (Check all that apply)

	Anemia		Behavioral issues		Heart trouble		Poor appetite
	Asthma		Chronic earaches		Hypertension		Paralysis
	Allergies		Constipation		Headaches / Migraines		Ruptures/Hernias
	Arm problems		Convulsions		Hyperactivity		Sinus trouble
	Blood disorders		Diabetes		Joint problems		Tuberculosis
	Backaches		Dizziness		Leg problems		Walking problems
	Broken bones		Digestive disorders		Muscle jerking		Other (Specify:)
	Bed wetting		Frequent colds/flu		Neck problems		

Present History & Allergies: _____

_____

_____

Surgeries: _____

_____

_____

ANDERSON UPPER CERVICAL

1099 MERCHANTS DRIVE, SUITE A, DALLAS, GEORGIA 30132-3005
PHONE: 770-443-0787 ~ FAX: 770-443-3890 ~ EMAIL: info@andersonuc.com

CS#_____

Accidents, Falls or Traumas: _____
_____
_____

Medications: _____
_____
_____

Family History: _____
_____
_____

ASSIGNMENT & RELEASE: AUTHORIZATION FOR CARE OF A MINOR

Upper Cervical examination and Chiropractic care including but not limited to spinal adjustments. While the chances of experiencing complications are small, it is the practice of this office to inform our patients about them. These complications and detox possibilities include, but are not limited to, soreness, inflammation, dizziness, and a temporary worsening of symptoms.

I have read and understand the above statements regarding possible detox symptoms. I also understand that there is no guarantee or warranty for a specific cure or result.

I HEREBY AUTHORIZE **ANDERSON UPPER CERVICAL** AND ITS DOCTOR(S) TO ADMINISTER CARE AS THEY DEEM NECESSARY FOR MY CHILD/WARD.

_____/_____. _____/____/_____.
PARENT / GUARDIAN SIGNATURE **RELATIONSHIP TO PATIENT** **DATE**

Financial Responsibility: Ultimately, all services rendered to your child are your responsibility. We will do our part in submitting services to your insurance company (ies) and/or attorney when applicable. However, if your account becomes delinquent (i.e. no payment has been made for 3 months or more), we reserve the right to send it along with any incurred fees to collections.

_____/_____. _____/____/_____.
PARENT / GUARDIAN SIGNATURE **RELATIONSHIP TO PATIENT** **DATE**