

**Bayside Chiropractic, pc**  
**CONFIDENTIAL PEDIATRIC PATIENT INFORMATION SHEET**  
**291 Waterman Street, Providence, RI**  
**401-223-0111**

Child's Name \_\_\_\_\_ Date \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Age \_\_\_\_\_ Birth Date \_\_\_\_\_ School \_\_\_\_\_

Parents names \_\_\_\_\_ Occupations \_\_\_\_\_

Employer \_\_\_\_\_ Office Phone \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Date of last physical examination \_\_\_\_\_

Has child been treated for any health conditions by a physician in the last year? Yes \_\_\_ No \_\_\_

Describe \_\_\_\_\_

Primary complaints \_\_\_\_\_

How long has this been a problem? \_\_\_\_\_

Has your child been to a chiropractor before? \_\_\_ Yes \_\_\_ No Who? \_\_\_\_\_

Is child's current pain/complaint due to an automobile accident \_\_\_ Yes \_\_\_ No

If yes, date occurred \_\_\_\_\_ What happened? \_\_\_\_\_

Auto Insurance company involved \_\_\_\_\_

Policy and claim # \_\_\_\_\_

Name of person responsible for payment \_\_\_\_\_

Contact info \_\_\_\_\_

Are you insured? Yes \_\_\_ No \_\_\_ Company \_\_\_\_\_

Insurance phone # \_\_\_\_\_ Insurance Policy # \_\_\_\_\_

Insured's Name \_\_\_\_\_

Guardian/Parent's Signature authorizing care for minor child \_\_\_\_\_

Promptly update our office as to any changes in your address, phone numbers or insurance information.



Bayside Chiropractic, PC Pediatric History Form

Would you describe child's general health as: Healthy \_\_\_\_ Sensitive \_\_\_\_ Sickly \_\_\_\_

Why? \_\_\_\_\_

Would you describe child's behavior as: Content \_\_\_\_ Agitated \_\_\_\_ Anxious/fearful \_\_\_\_

Fussy \_\_\_\_ Hard to manage \_\_\_\_ Temper tantrums \_\_\_\_ Clingy \_\_\_\_ Easy \_\_\_\_

Why? \_\_\_\_\_

Describe child's sleep habits \_\_\_\_\_

**Has your child experienced:**

Drug reactions Yes \_\_\_\_ No \_\_\_\_

School problems Yes \_\_\_\_ No \_\_\_\_

Surgery Yes \_\_\_\_ No \_\_\_\_

Hospitalizations Yes \_\_\_\_ No \_\_\_\_

Emotional issues Yes \_\_\_\_ No \_\_\_\_

Urinary infections Yes \_\_\_\_ No \_\_\_\_

Colic Yes \_\_\_\_ No \_\_\_\_

Feeding problems Yes \_\_\_\_ No \_\_\_\_

Skin rashes Yes \_\_\_\_ No \_\_\_\_

Heart Murmur Yes \_\_\_\_ No \_\_\_\_

Trauma Yes \_\_\_\_ No \_\_\_\_

Abuse Yes \_\_\_\_ No \_\_\_\_

Other \_\_\_\_\_

Abnormal bowel movements Yes \_\_\_\_ No \_\_\_\_ How often \_\_\_\_\_

More info on yes answers: \_\_\_\_\_

Is your child taking any medications? \_\_\_\_\_

Is your child taking supplements/vitamins? \_\_\_\_\_

Does your child have a special diet or food sensitivities? \_\_\_\_\_

Is there anything else we should know about you and your child? \_\_\_\_\_

I, \_\_\_\_\_'s, parent/guardian, hereby grant consent for Chiropractic treatment by Paul J. O'Brien, Jr, DC. I have authority to grant consent for treatment.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship to child

\_\_\_\_\_  
Signature

\_\_\_\_\_  
date