

- Dr. Michael Farrell, D.C.
- Dr. April Cardwell, D.C.

Pediatric Application Form

Patient Survey

Child's Name _____ Birth Date _____ M/F ____
 Address _____
 City _____ State _____ Zip _____
 Parent/Guardian Names _____ Phone _____
 How did you hear about us? _____
 Reasons for visit? _____
 Referring Physician: _____ Phone #: _____
 General Physician or Specialist: _____ Phone #: _____

Health Conditions

Please list all prescription or over the counter medications/antibiotics your child has taken in the last year:

Please check any of the following conditions your child has suffered from:

- | | | |
|---|--|---|
| <input type="checkbox"/> Ear Infections | <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Growing Pains |
| <input type="checkbox"/> Asthma/Allergies | <input type="checkbox"/> Chronic rash/eczema | <input type="checkbox"/> Digestive Problems |
| <input type="checkbox"/> Colic | <input type="checkbox"/> Chronic colds/flu | |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Recurring Fever | |
| <input type="checkbox"/> Bed wetting | <input type="checkbox"/> Temper Tantrums | |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Headaches/Migraines | |

Please list any health conditions not mentioned _____

Please list any medications/surgeries _____

Please list any traumas (falls, car accidents, etc.) _____

Pregnancy/Birth

Place of Birth: Homebirth Birthing Center Hospital
 Midwife Delivery or Doctor Delivery

Complications during pregnancy? _____

Complications during delivery? _____

Birth Intervention: Forceps Vacuum Extraction Cesarean Section – Planned or Emergency

Medications During Pregnancy? _____

Medications During Delivery? _____

