

LionHeart Chiropractic

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Pediatric Patient Introduction

Date: _____

Child's Name: _____ Mother's Name: _____
First Middle Last First Middle Last

Social Security Number: _____ Father's Name: _____
First Middle Last

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Mother/Father Work Phone: _____

Birth Date: ____/____/____ Age: _____ Sex: Male/Female Number of Siblings: _____

Current Weight: _____ Current Height: _____

Place of Birth: _____ Home _____ Birthing Center _____ Hospital _____ Other

Type of Birth: _____ Normal Vaginal _____ Forceps _____ Breech _____ Cesarean

Problems during Pregnancy (Please describe): _____

Problems during Labor/Delivery: (Please describes): _____

APGAR Scores: _____ Was there presence at birth of: _____ Jaundice (Yellow) _____ Cyanosis (Blue)
Congenital Anomalies/defects: _____

Infant Feeding: _____ Breast _____ Bottle _____ Formula

Problems with latching? _____

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

Name of Obstetrician/Midwife: _____

Name _____ Location

Name of Pediatrician/Family MD: _____

Name _____ Location

Date of last visit to MD: _____ Purpose: _____

Previous Chiropractor: _____

Name _____ Location

Immunization History: _____

Purpose of this visit: _____

Has your child ever been treated on an emergency basis? Yes/No
Please describe: _____

Authorization for care of Minor

I hereby authorize LionHeart Chiropractic and doctor(s) to administer care, as they so deem necessary to my son/daughter/ward (upon approval of parent or guardian)

Signed: _____ Date: _____