OPTIMUM PERFORMANCE CENTRE

PEDIATRIC PATIENT INTRODUCTION

Date:

Child's Name:_____D.O.B. M/____D/____Y/____ A.H.C.#:_____

Mother's Name: _____ Father's Name: _____

Address: _____ City/Town: _____ Postal Code:_____

Phone: _____ Sex:_____ Number of Siblings: _____

Mother's Work Phone: _____ Father's Work Phone: _____

Reason For Appointment: _____

Recurring/Past Problem? _____Date Symptoms Appeared: _____

Obstetrician/Midwife: _____ Pediatrician/Family MD: _____

Date of Last Medical Visit: _____ Reason: _____

Immunization History: _____

Medical Emergency History: _____

Surgery: _____ Accidents: _____

Medications: _____

Family History: _____

Child Medical History: _____

_____

_____

Birth Weight: _____ Current Weight: _____

Birth Length: _____ Current Length: _____

Type of Birth: ☐ Normal ☐ Forceps ☐ Breech ☐ Cesarean

☐ Home ☐ Birthing Center ☐ Hospital

Problems During Pregnancy: _____

_____

Problems During Labor/Delivery: _____

_____

APGAR Scores: _____ _____ At Birth: ☐ Jaundice ☐ Cyanosis

Congenital Abnormalities/Defects: _____

Feeding: ☐ Breast ☐ Bottle ☐ Formula

Sleep Per Night: _____hrs Sleep Quality: ☐ Good ☐ Fair ☐ Poor

Please Turn Over ➔

Age of Child When: ____ **Responded to Sound** ____ **Crawl**
____ **Follow Object with Eyes** ____ **Stand**
____ **Hold Head Up** ____ **Sit Alone**
____ **Walk alone**

Childhood Diseases: ☐ **Chickenpox** ☐ **Mumps** ☐ **Measles** ☐ **Whooping Cough**
☐ **Other:** _____

Check Those Your Child is Suffering From or has Suffered From in the Past:

☐ **Dizziness**	☐ **Backaches**	☐ **Heart Trouble**	☐ **Chronic Fatigue**
☐ **Diabetes**	☐ **Tuberculosis**	☐ **Hypertension**	☐ **Poor Appetite**
☐ **Arthritis**	☐ **Headaches**	☐ **Bed Wetting**	☐ **Neck Problems**
☐ **Neuritis**	☐ **Constipation**	☐ **Sinus Trouble**	☐ **Digestive Disorder**
☐ **Anemia**	☐ **Diarrhea**	☐ **Rheumatic Fever**	☐ **Orthopedic Problems**
☐ **Asthma**	☐ **Hyperactivity**	☐ **Muscle Jerking**	☐ **Behavioral Problems**
☐ **Colds/Flu**	☐ **Convulsions**	☐ **Broken Bones**	☐ **Sugar Concentration**
☐ **Fainting**	☐ **Leg Problems**	☐ **Joint Problems**	☐ **Ruptures/Hernias**
☐ **Paralysis**	☐ **Arm Problems**	☐ **"Growing Pains"**	☐ **Walking Problems**
☐ **Allergies**	☐ **Stomach Aches**	☐ **Blood Disorders**	

☐ **Other:** _____

Authorization For Care of Minor

I Hereby authorize Optimum Performance Centre and it's Doctors to Administer care as they so deem necessary to my Son/Daughter/Ward, upon approval of parent or guardian. 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. X-rays remain the property of this clinic unless requested by the patient to be transferred to another authorized service provider.

Patient Name: _____ Parent/Guardian Name: _____

Signed: _____ Witnessed: _____ Date: _____