PEDIATRIC NEW PATIENT INFORMATION

Date: _____

PATIENT INFORMATION

Child's Name: _____ Child's Nickname: _____

Reason for Visit: _____

Sex: M / F Date of Birth: _____ Age: _____ Child's SS #: _____

Child's Home Phone #: _____

Child's Home Address: _____

Who may we thank for referring you? _____

FAMILY INFORMATION

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

Home Phone #: _____ Home Phone #: _____

Work Phone #: _____ Work Phone #: _____

Parent's Marital Status: Married ____ Single ____ Divorced ____ Widowed ____

List Ages of Other Children in Family: _____

Predominant language used at home: _____

PAYMENT INFORMATION

Please read and sign our Financial Agreement. Does your health insurance cover chiropractic? Y / N

If you have insurance that may cover chiropractic services, please provide your current insurance card so that we may make a copy. Additionally, please enter the following information relating to the person who is responsible for the child's health insurance coverage.

Insured's Name: _____ Birth date: _____ SS #: _____

Insurance Company Name: _____ Phone No: _____

Insurance Company Address to send claims: _____

Employer: _____ Group No: _____ Insured's ID #: _____

CONSENT TO TREAT

Being the parent or legal guardian of this child, I hereby authorize this office and its doctors to examine and administer care to my son / daughter named _____ as the examining / treating doctor deems necessary.

I understand and agree the I am personally responsible for payment of all fees charged by this office for such care.

Parent's Name: _____ Signature _____

Date: _____ Witnessed by: _____

PREGNANCY HISTORY

Today's Date _____

Child's Name _____ Sex: M F Date of Birth _____ Age _____

Mother's Name: _____ How many children do you have? _____

What was the term of your pregnancy? _____ weeks

DURING YOUR PREGNANCY, DID YOU HAVE ANY OF THE FOLLOWING:

	Yes	No	
Falls?	☐	☐	_____
Motor Vehicle Accidents?	☐	☐	_____
Near-miss MVA	☐	☐	_____
High B.P?	☐	☐	_____
Diabetes?	☐	☐	_____
Anemia?	☐	☐	_____
Morning sickness?	☐	☐	_____
Indigestion?	☐	☐	_____
Seizures?	☐	☐	_____
Swollen ankles?	☐	☐	_____
Thyroid problems?	☐	☐	_____
Heart problems?	☐	☐	_____
Back pain?	☐	☐	_____
Abnormal bleeding?	☐	☐	_____
Were you hospitalized?	☐	☐	_____
Any other Illnesses?	☐	☐	_____

DURING YOUR PREGNANCY, DID YOU USE ANY OF THE FOLLOWING:

	Yes	No	
Tobacco?	☐	☐	_____
Alcohol?	☐	☐	_____
Non-prescribed drugs?	☐	☐	_____
Prescription medications?	☐	☐	Medication _____ Reason _____
Over -the-counter meds?	☐	☐	Medication _____ Reason _____

BIRTH HISTORY

LABOR AND DELIVERY

How long was the labor from the first regular contractions to the birth? _____ hours

How long was the 2nd stage (the pushing phase) of the labor? _____ hours

	Yes	No	
Hospital birth	☐	☐	_____
Home birth	☐	☐	_____
Midwife assisted	☐	☐	_____
Vaginal Delivery	☐	☐	_____
Planned C-section	☐	☐	_____
Emergency C-section	☐	☐	_____
Was Birth Induced (Pitocin)	☐	☐	_____
Forceps delivery	☐	☐	_____
Vacuum extraction	☐	☐	_____
Anesthesia administered	☐	☐	_____
Fetal distress	☐	☐	_____
Meconium staining	☐	☐	_____
Head presentation	☐	☐	_____
Face presentation	☐	☐	_____
Breech presentation	☐	☐	_____

BABY'S CONDITION IMMEDIATELY AFTER BIRTH:

Apgar Scores: At 1 minute ____/ 10 At 5 minutes ____/ 10

Baby's Crying Baby Cried Immediately After Birth ____

Cried Strongly ____ Weak Cry ____ Did Not Cry for ____ minutes

Baby's Color Pink all over ____ Blue face ____ Blue Hands/feet ____

Baby's activity Arms and legs actively moving ____ Floppy baby ____

Intensive Care Was required ____ Days in Neonatal Intensive Care Unit ____

Medication given at birth? _____ Vaccines administered _____

Birth weight _____ lbs / kgs Birth length _____ ins / cms Baby home on day _____

INFANT HISTORY
2 months to 2 years

Today's Date _____

Patient's Name _____ Sex: M F Date of Birth _____ Age ___

The following questions are designed to help the doctor provide a detailed evaluation of your child.

NUTRITION

Yes No
☐ ☐ Is your child still being breast fed? If no, for how long was he/she breast fed _____

If still breast-feeding, how much cow's milk does the mother consume each day? _____

Yes No
☐ ☐ Is your child formula fed? Which formula or other milk source? _____

Yes No
☐ ☐ Is your child eating solid food? What foods does his/her diet contain? _____

_____ What is your child's favorite food? _____

Yes No
☐ ☐ Does your child have any feeding difficulties? _____

Yes No
☐ ☐ Does your child have any digestive disturbances? _____

Yes No
☐ ☐ Does your child have any food allergies? _____

Yes No
☐ ☐ Does your child have any persistent or intermittent skin rashes? _____

Yes No
☐ ☐ Is your child receiving any vitamin supplements? _____

TRAUMA

Yes No
☐ ☐ Has your child had any recent falls or trauma?

Describe the trauma and the date it occurred? _____

Yes No
☐ ☐ Has your child ever fallen down stairs or fallen from any height? _____

Yes No
☐ ☐ Has your child ever been in a motor vehicle collision or near-miss? _____

Yes No
☐ ☐ Has your child ever had a bone fracture or joint dislocation? _____

Yes No
☐ ☐ Has your child had any other trauma or injuries? _____

Yes No
☐ ☐ Does your child ever bang his/her head repeatedly against a wall, bed or other object?_____

INFANT HISTORY

2 months to 2 years

GROWTH AND DEVELOPMENT

Yes ☐ No ☐ Can your child sit unsupported? At what age did your child start to sit-up? _____ mths

Yes ☐ No ☐ Is your child crawling yet? At what age did your child start crawling? _____ mths

Yes ☐ No ☐ Is your child walking yet? At what age did your child start to walk? _____ mths

Yes ☐ No ☐ Does your child often trip and fall? _____

Yes ☐ No ☐ Does your have any other concerns about your child's growth and development? _____

HEALTH HISTORY

Yes ☐ No ☐ Has your child had colic? _____

Yes ☐ No ☐ Has your child had any upper respiratory infections? How often? _____

Yes ☐ No ☐ Has your child had asthma? _____

Yes ☐ No ☐ Does your child ever complain of back or neck pain? _____

Yes ☐ No ☐ Does your child ever complain of pains in the arms or legs? _____

Yes ☐ No ☐ Does your child ever complain of headaches? _____

Yes ☐ No ☐ Has your child had any earaches ? At what age did the first earache occur _____

Yes ☐ No ☐ How frequently does your child have earaches? _____

Yes ☐ No ☐ Do your child's earaches usually tend to occur in the same ear? Is it right, left or both? ___

Yes ☐ No ☐ Has your child had any other illnesses?
Please list each illness and its approximate date _____

_____

Yes ☐ No ☐ Is your child presently receiving any medications ? _____

Yes ☐ No ☐ Has your child ever been to a hospital or emergency room for evaluation or treatment? _____

Yes ☐ No ☐ Has your child recently been vaccinated? _____

Yes ☐ No ☐ Do you have any other concerns about your child's health? _____