PEDIATRIC NEW PATIENT INFORMATION

Today's Date: _____

PATIENT INFORMATION

Child's First Name: _____ Last Name: _____

Reason for Visit: _____

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

Home Phone #: _____

Home Address: _____

Who may we thank for referring you? _____

FAMILY INFORMATION

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

Does one or both parents have custody? _____

Home Phone #: _____ Home Phone #: _____

Work Phone #: _____ Work Phone #: _____

Parent's Marital Status: Married _____ Single _____Divorced _____Widowed_____

List Ages of Other Children in Family: _____

PAYMENT INFORMATION

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

If you have health insurance that may cover chiropractic care, 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: _____ DOB: _____ SS#: _____

Insurance Company Name: _____Phone #: _____

Insurance Company address to send claims: _____

Employer: _____ Group #_____ Insured's ID #: _____

CONSENT FOR CHIROPRACTIC CARE

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 (name)_____as the doctor deems necessary.

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

Guardian's Name (Printed) _____

Guardian Signature: _____

Date: _____Witnessed by: _____

PEDIATRIC NEW PATIENT INFORMATION

PURPOSE FOR CONTACTING US? _____

Other Doctors seen for this Condition: _____Yes _____No

Doctors' Names & Prior Treatments: _____

Other Health Problems: _____

Circle any of the following Conditions your Child has Suffered from during the past SIX Months:

Ear Infections	Scoliosis	Seizures	Chronic Cough	Headaches
Asthma/ Allergies	ADHD	Bed Wetting	Car Accidents	Recurring Fevers
Digestive Problems	Temper Tantrums	Colic	Growing/Back Pains	Other_____

Family History:_____

Previous Chiropractor: _____

Date of Last Visit: _____ Reason: _____

Name of Pediatrician: _____

Date of Last Visit: _____ Reason: _____

Are you satisfied with the Care your Child has received? _____Yes _____No

Number of Doses of ANTIBIOTICS your Child has taken:

During the past SIX Months: _____ During His/Her Lifetime: _____

Number of OTHER PRESCRIPTION MEDICATIONS your Child has taken:

During the Last SIX Months: _____ During His/Her Lifetime: _____

List: _____

Vaccination History: _____

CHILDHOOD DISEASES:

Chicken Pox	Y / N	Age: _____	Mumps	Y / N	Age: _____
Rubella	Y / N	Age: _____	Whooping Cough	Y / N	Age: _____
Rubeola	Y / N	Age: _____	Other	Y / N	Age: _____

PEDIATRIC NEW PATIENT INFORMATION

PRENATAL HISTORY:

Name of Obstetrician/Midwife: _____

Complications During Pregnancy: _____Yes _____No List: _____

Ultrasounds During Pregnancy: _____Yes _____No Number: _____

Medications During Pregnancy/Delivery: _____Yes _____No List: _____

Cigarette/Alcohol Use During Pregnancy: _____Yes _____No

Location of Birth: _____Hospital _____Birthing Center _____Home

Birth Intervention: _____ Forceps _____Vacuum Extraction

_____ C Section (Emergency or Planned)

Complications During Delivery: _____Yes _____No List: _____

Genetic Disorders or Disabilities: _____Yes _____No List: _____

Birth Weight: _____ Birth Length: _____ APGAR Scores: _____ _____

FEEDING HISTORY:

Breast Fed: _____Yes _____No How Long: _____

Formula Fed: _____Yes _____No How Long: _____ Type: _____

Introduced Solids At: _____ Months Cow's Milk At: _____ Months

Food/ Juice Allergies: _____Yes _____No List: _____

DEVELOPMENTAL HISTORY:

At what age was your Child able to:

_____Respond to Sound _____Cross Crawl _____Respond to Visual Stimuli

_____Stand Alone _____Hold Head Up _____Walk Alone _____Sit Up

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e. a bed, changing table, down stairs. etc..) Was this case with your child? _____Yes _____No

Is your Child involved in any High Impact/ Contact type sports(Football, Gymnastics, etc..)?

_____Yes _____No List: _____

Has your Child been involved in a Car Accident or seen on an Emergency Basis ?

_____Yes _____No List: _____

Other Traumas or Prior Surgeries: _____Yes _____ND List: _____

NAME: _____ DATE: _____

DIFFERENTIAL DIAGNOSIS

- What complaints / conditions do you have?
- Please list the order in which you would like these conditions treated.
- What time of the day are these conditions worse?

	Condition	Time	Re-Exam (office use only)
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____

(Examples include: back and neck pain, headaches, shoulder, knees, wrist, TMJ, eyes, ears, nose and throat (E ENT), heart, lung, digestive, urinary, reproductive, skin, hormone, thyroid, allergies, depression, anxiety, insomnia, lack of energy)

- In oriental medicine dreams and emotions are significant in our diagnosis.
- Do you have vivid dreams? □ YES □ NO

- What emotions are most prevelant? (circle all that apply)
  anger, worry, joy, panic, anxiety, sadness, tears, fear, grief, weeping, obsession

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