PEDIATRIC NEW PATIENT INFORMATION

Date: _____ Email Address: _____

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

Birthdate: _____ Birthdate: _____

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

Home Phone #: _____ Home Phone #: _____

Work Phone #: _____ Work Phone #: _____

SS# _____ SS# _____

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	☐	☐	_____

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 _____

NEWBORN HISTORY

Birth to 2 months

Today's Date _____

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

The following questions are designed to help the doctor provide the best possible spinal care for your child.

How many hours does your baby sleep between feeds? During day _____ At night _____

Yes ☐ No ☐ Does your baby go to sleep easily? _____

Yes ☐ No ☐ Does baby have a preferred sleeping position ? _____

Yes ☐ No ☐ Does baby cry if you change this sleeping position? _____

Yes ☐ No ☐ Does baby have any feeding difficulties? _____

Yes ☐ No ☐ Is baby being breast fed? If no, for how long was baby breast fed _____ weeks/mths

Yes ☐ No ☐ Does baby have a one sided breast-feeding preference? Preferred breast Left / Right

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

Yes ☐ No ☐ Does baby frequently spit-up after feeding? _____

Yes ☐ No ☐ Does your baby cry a lot? For how many hours each day? _____

Yes ☐ No ☐ Does baby pass a lot of intestinal gas? _____

Yes ☐ No ☐ Does baby have a preferred head position? _____

Yes ☐ No ☐ Does baby frequently arch his/her head and neck backwards? _____

Yes ☐ No ☐ Does baby cry or become irritable during a diaper change? _____

Yes ☐ No ☐ Has baby ever had a fever? _____

Yes ☐ No ☐ Has baby had any falls? _____

Yes ☐ No ☐ Has baby been in a car accident or near-miss? _____

Yes ☐ No ☐ Has baby had any other trauma? _____

Yes ☐ No ☐ Has your baby been vaccinated? _____

Yes ☐ No ☐ Do you have any other concerns you wish to discuss? _____

_____