

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?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Motor Vehicle Accidents?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Near-miss MVA	<input type="checkbox"/>	<input type="checkbox"/>	_____
High B.P?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anemia?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Morning sickness?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Indigestion?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seizures?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Swollen ankles?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid problems?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart problems?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Back pain?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Abnormal bleeding?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Were you hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Any other illnesses?	<input type="checkbox"/>	<input type="checkbox"/>	_____

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

	Yes	No	
Tobacco?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Non-prescribed drugs?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Prescription medications?	<input type="checkbox"/>	<input type="checkbox"/>	Medication _____ Reason _____
Over-the-counter meds?	<input type="checkbox"/>	<input type="checkbox"/>	Medication _____ Reason _____

PRE-SCHOOL CHILD HISTORY
3 years to 5 years

Today's Date _____

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

Age _____

Reason for Today's Visit _____

Yes No

Does your child complain of pain or discomfort? If yes, when did this occur? _____

Was onset Sudden or Gradual

Is problem Constant or Intermittent

Yes No

Has your child ever had this problem before? _____

Yes No

Has your child previously been treated for this problem? By whom? _____

Yes No

Has your child previously had chiropractic care? Previous chiropractor _____

HEALTH HISTORY

Yes No

Does your child ever complain of back or neck pain? _____

Yes No

Does your child ever complain of pains in the legs or arms? _____

Yes No

Does your child ever complain of headaches? _____

Yes No

Has your child had asthma? _____

Yes No

Is your child allergic to anything? _____

Yes No

Are there any smokers in the child's home? _____

Yes No

Has your child had any earaches? At what age did the child's first earache occur? _____

How frequently does your child have earaches? _____

In which ear do your child's earaches usually occur? Right Left Both

Yes No

Is your child presently taking any prescribed medication? _____

Please list any other illness which have been a concern for your child

Please list any surgeries your child has had

Yes No

Do you have any other concerns about your child's health? _____