New Patient Application- Pediatric

Welcome to our Practice! Please thoroughly complete all questions. Thank you.

Name:______________________________ Today's Date:________________

Preferred Name: ______________________ Birthdate: ____/____/____ Age:______

Address:____

City/State/Zip:_____________________________ Social Security #:_______________________

Who may we thank for referring you? ____

Siblings: Yes / No

Name: __________________________________ Age:_________________________

Name: __________________________________ Age:_________________________

Name: __________________________________ Age:_________________________

Name: __________________________________ Age:_________________________

Parents Name: _______________________ Social Security #:_______________________

Phone: Home:_________________ Work:__________________ Cell:__________________________

Emergency Contact: ______________________ Phone: _________________ Other: ___________

Favorite hobbies or interests: ____

Child's Prior Doctor of Chiropractic: ____

City, State: ___________ Approximate date of last Chiropractic treatment: ______________

Chiropractic adjusting techniques you've had success with: _____________________________

Pediatrician's name: ____

Phone:___________________ City, State: _______

Please rate 1 (poor) to 10 (excellent) the quality of healthcare you feel you receive from your GP:

____

Other Specialists you are currently under care with:

Name: __________________________________ Phone:_________________________

Name: __________________________________ Phone:_________________________

Method of payment for first visit

____ Cash ____ Check ____ Credit Card Person

Responsible for payment:

Name: ________________________________

Phone Number:_________________________

Address: ______________________________

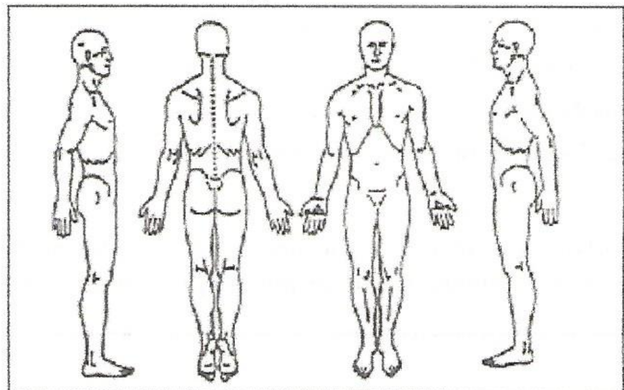
City:__________________________________

State/Zip:______________________________

Do you have Health (crisis) Insurance? Y N

Insurance Company: ____________________

Mark Area(s) of Health Concerns:



Health reasons for consulting our office:

1.______________________________ 2. ______________________________

3.______________________________ 4. ______________________________

Has the child had the same or similar problem(s) before? ___Yes ___No

How long?_______________ Please explain:______________________________

____

Does this condition interfere with: ____school _____sleep ____ daily routine

Father/Mother/Brother/Sister, with similar problems? ______________________________

Is this the result of an auto injury: Yes / No If so, when? ______________________

Other doctors who have treated this problem: ______________________________

What treatments did your child receive: ______________________________

Medication(s) your child currently takes: ______________________________

Does your child take supplements? Yes / No If yes, please list______________________

For Menstruating Female Patients. Is there any chance your child is pregnant? Yes____ No ____

What do you understand chiropractic care to be? ______________________________

Do you know what a subluxation is? Yes / No If yes, please describe:

____

Does your child play any sports or exercise regularly? Yes or No

If yes, please describe____

Did the mother have an ultrasound during this pregnancy? _______ Frequency _________

Place of Birth: Home / Birth Center / Hospital Type of Birth: Vaginal / C-section

Was anesthesia used? ___Spinal ___ Epidural ___ Other Was Labor induced? Y / N Why: ___________

What position was the child delivered: Squatting / On Back

Birth Trauma: Doctor assisted – twisting, pulling Vacuum Extraction / Forceps

Newborn Trauma (medical procedures and tests):______________________________

Did your child breast-feed? Y / N How Long________

Please describe any injuries, falls or traumas: ______________________________

Do you or have you had any of the following? Please write *C* of current and *P* for Past

___Angina ___Arthritis ___Asthma ___Allergies ___Bed wetting ___Cancer ___Colic ___Colds ___Diabetes ___Ear infections

___"Growing pains" ___Headaches ___Heart Disease ___Kidney Disease ___Learning disorders ___Migraines

___Numbness/tingling ___ Sciatica ___Seizures ___Sinus Problems ___Spinal curvature ___Stroke ___Thyroid disorder ___Ulcers

Other Medical diagnoses or anything else you are concerned about: ______________________

____

The above information is true and accurate to the best of my knowledge. My reason for consultation with the Doctor is for evaluation of my physical health and the potential for improvement.

Parent or Guardian Signature: ______________________________ Date: __/__/__