Pediatric New Patient Information

Patient Information

Child's Name _____

Parent(s)/Guardian(s)_____

Address _____City/State/Zip_____

Home Phone_____Work Phone_____Cell Phone_____

Is it okay to contact you at work? ❑Yes ❑No

E-mail _____

Child's Birth date_____ Age _____ Weight _____ Height _____

Date of your child's late Chiropractic Adjustment? _____

How did you find out about our office?

_____

Is your child receiving care from other health professionals? ❑Yes ❑No If yes, please name & specialty

_____

Please list any drugs or medications your child is taking

_____

Please list any vitamins/herbs/homeopathics/other your child is taking

_____

Allergies? _____

Favorite Hobbies/Activities

_____

Current Health

Is there a health condition that brings your child to our office?_____

_____

When did the symptoms first begin? _____

Did the problem start: ❑Suddenly ❑Gradually ❑ Post-Injury

Is this condition ❑Getting Worse ❑Improving ❑Intermittent ❑Constant ❑Not Sure

What makes the problem better and/or worse?

_____

_____

Has your child ever had a similar condition? ❑Yes ❑No

Has your child been treated for this problem before? ❑Yes ❑No

Does your child eat well? ❑Yes ❑No Does your child have regular bowel/bladder movements? ❑Yes ❑No

Has your child ever been checked for vertebral Subluxations? ❑Yes ❑No ❑Don't Know

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Health History

Child's birth was ❑Natural vaginal (no medications/interventions)❑ Vaginal with interventions❑ Induction ❑Pain medication ❑Epidural ❑Episiotomy ❑Vacuum extraction ❑Forceps ❑C-section ❑ Scheduled ❑Emergency ❑ Other _____

Please explain interventions/complications_____

Child's birth weight_____ Child's birth height_____APGAR score at birth_____APGAR score (5 min)_____

At what age did your child: Respond to sound ____ Follow an object ____ Hold head up ____ Vocalize ____

Sit alone_____ Teethe ____ Crawl _____ Walk_____

Patient/Hospitalizations/Surgical history:_____

_____

Please list any major injuries, accidents, falls and/or fractures your child has sustained in his/her lifetime:

_____

Is/was your child breastfed? ❑Yes ❑No If yes, how long?_____If not, please explain:_____

_____

Formula introduced at age____ What type? _____

Introduction of cow's milk at age ____ Began solid foods at age____ Any difficulty with bonding? ❑Yes ❑No

Did mother smoke during pregnancy? ❑Yes ❑No Did mother drink alcohol during pregnancy? ❑Yes ❑No

Any illness of mother during pregnancy? ❑Yes ❑No If yes, please explain_____

List any drugs/medications (including over the counter)/supplements taken during pregnancy

_____

_____

Has your child ever had: ❑Vision Problems ❑Headaches ❑Breathing problems/Asthma ❑ADD/ADHD ❑Ear Aches/infections ❑Frequent Colds ❑Colic ❑Digestive Problems ❑Bed Wetting

Has your child received any vaccinations? ❑Yes ❑No If yes, which ones?_____

_____

Has child received any antibiotics? ❑Yes ❑No If yes, how many times and why?_____

_____

Any behavioral problems? ❑Yes ❑No Please explain_____

_____

Any night terrors, sleepwalking or difficulty sleeping? ❑Yes ❑No

Does your child seem "normal" for their age? ❑Yes ❑No Please explain_____

_____

The above information is true and accurate to the best of my knowledge. I authorize the NCWC to render necessary services to me and understand that I am responsible for all charges incurred.

Parent/Guardian Signature _____ **Date** _____