

# 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 \_\_\_\_\_