

PEDIATRIC NEW PATIENT INFORMATION

PERSONAL INFORMATION:

Name: _____
Address: _____

City: _____
State: _____ Zip Code: _____
Daytime Phone #: _____
Other Phone #(s): _____
Date Of Birth: _____ / _____ / _____
Age: _____ Gender: *male / female*
Social Security #: _____ - _____ - _____

Parent / Guardian's Name(s): _____

Siblings, Names & Ages: _____

Any Special Circumstances: _____

Emergency Contact Person: _____
Relationship: _____
Phone #(s): _____

STUDENT / CHILDCARE INFORMATION:

Patient Status: *student / daycare / pre-school / at-home*

School / Daycare: _____
If Applicable, Grade / Level: _____

FINANCIAL INFORMATION:

Person Responsible For Payment: _____
Payment By: *cash / check / credit card / insurance*

If paying by insurance, please take your insurance card to the front desk to copy. If you do not have a card, please ask for the proper forms to fill out.

PRESENT HISTORY:

Rate Patient's Health: *excellent / good / fair / poor*
Rate Patient's Diet: *excellent / good / fair / poor*
Level Of Activity: *high / moderate / low / none*
Last Physical Exam Date: _____
Doctor's Name: _____
Medical Conditions: _____

Prescriptions: _____

Over – The – Counter Drugs? _____

Supplements? _____

Amount Of Sleep Per Night: _____
Sleeps On: *back / right side / left side / stomach*
Please Check All That Apply.....
_____ uses more than 1 pillow under their head
_____ sleeps with their arms over their head
_____ sleeps in the fetal position (curled up)
_____ sleeps twisted (½ side & ½ back / stomach)
_____ uses a waterbed / very soft mattress
_____ carries a bag / backpack usually on one side
_____ pops / cracks neck, back or other joints
Reason For Visit: _____

PAST HISTORY:

Pregnancy Discovered? *right away / not until* _____
Pregnancy Specialist? *right away / not until* _____
Length / Pregnancy? *full term / early* _____
Pregnancy Complications? *yes / no*
Mother's Diet? *excellent / good / fair / poor*
Mother – Medications / Supplements? *yes / no*
Mother – Exposed To Toxins? *yes / no / unsure*
Mother – Falls / Accidents? *yes / no*
Mother – Chiropractic Care? *yes / no*
Type Of Delivery? *vaginal / breech vaginal / c-section*
Length / Labor: _____
Time Spent Pushing: _____
Used: *inducing drugs / pain management / antibiotics*
/ vacuum extraction / forceps / pulling / other
Complications: _____

Breast Fed? *yes / no (If yes, how long? _____)*
Please Circle All That Apply: *fractures / dislocations*
head injuries / falls / injuries / car accidents /
surgeries / hospitalizations / seizures / black-outs
/ other: _____
Past Medical Conditions: _____

Problems With: *colic / hyperactivity / bedwetting /*
constipation / allergies / asthma / ear - infections
/ frequently sick / other: _____
Significant Family History: *cancer / heart disease /*
stroke / diabetes / epilepsy / thyroid conditions
/ bleeding disorders / arthritis / migraines /
other: _____
Previous Chiropractic Care? *yes / no*
If Yes, Last Visit? _____
Lifts / Arch Supports? *yes / no*