Patient #: _______

Date: __________

PEDIATRIC NEW PATIENT INFORMATION

Name________________________________ Age_______ Date of Birth______________ Sex_______

Address____ City, State Zip___________________________

Phone______________________ Number of Siblings_______ Referred By__________________________

Parent/Guardian Name_______________________________ Relation to Patient_____________________

Chief Complaint

What is the main reason for bringing your child in to the office?______________________________________

____

When did this issue begin?____________________ How often does it occur? ☐Constantly ☐Comes and goes

How much does the complaint affect daily activities/routines? ☐Not at all ☐Somewhat ☐Often ☐All the time

Others seen for this problem____

History

Does your child have any food allergies? ☐Yes ☐No If yes, list___________________________________

Has your child been immunized? ☐Yes ☐No If so, did they have any negative reactions? ☐Yes ☐No

Has your child ever had any surgeries? ☐Yes ☐No If yes, explain__________________________________

Has your child ever been on antibiotics? ☐Yes ☐No If yes, how many rounds?____ Reason______________

Is your child currently taking any medications or vitamins? ☐Yes ☐No If yes, what type?_______________

____

Pregnancy

Were there any complications?____

Was mom on any medications? ☐Yes ☐No If yes, explain____

Did mom or dad smoke during the pregnancy? ☐No ☐Yes, mom ☐Yes, dad

Was the baby ever in a breech or transverse malposition? ☐Yes ☐No

Birth and Delivery

Where was the baby born? ☐Hospital ☐Home ☐Birthing Center ☐Other

Was the delivery: ☐Vaginal ☐C-Section Any devices used? ☐Forceps ☐Vacuum

How long was the labor?______________________ How long was the delivery (pushing)?______________

Labor/Delivery difficulties____

Congenital defects/anomalies____

Childhood diseases: ☐Measles ☐Mumps ☐Whooping Cough ☐Chicken Pox ☐Other______________

Other health problems____

Have any of the following occurred?

☐Fall from a tree	☐Car accident	☐Allergies/Asthma	☐ Leg/Knee pain
☐Fall off a bicycle	☐Sports accident	☐Hyperactivity/Autism	☐ Bed wetting
☐Fall off playground unit	☐Scoliosis	☐Learning difficulties	☐ Stomach pains
☐Other____________________			

Please check all health issues your child has experienced in the last **12 months**, even if they do not seem to relate to any current problem(s):

___Allergies	___Frequent Urination	___Loss of Memory	___Ringing in Ears
___Asthma	___Headache/Migraine	___Loss of Smell	___Shortness of Breath
___Behavior Problems	___Heartburn	___Loss of Taste	___Shoulder Pain
___Cancer	___Hernia/Ruptures	___Low Back Pain	___Sinus Congestion
___Constipation	___High Blood Pressure	___Menstrual Pain	___Sleeping Problems
___Depression	___Hip Pain	___Mood Swings	___Sore Throat
___Diabetes	___Indigestion/Gas	___Neck Pain/Stiffness	___Stomach Pain
___Diarrhea	___Irregular Cycle	___Nervousness	___Swollen Joints
___Dizziness	___Irritability	___Numbness in Fingers	___Tension/Anxiety
___Earaches	___Knee Pain	___Tingling in Arms/Hands	___Upper Back Pain
___Fainting	___Light Sensitivity	___Tingling in Legs/Feet	___Ulcers
___Fatigue	___Loss of Balance	___Poor Concentration	___Walking Problems

Number of hours your child sleeps per night:______________

Is there anything else we should know about your child?_______________________________________

____

AUTHORIZATION FOR CARE OF A MINOR

The information provided on this form is accurate to the best of my recollection, and I agree to allow Chiropractic Solutions to examine my child for further evaluation. I realize that I am responsible for all fees charged by this clinic and that I will pay for services as they are performed. X-rays remain the property of this clinic, yet are transferrable to other providers as needed.

Parent/Guardian Signature: ________________________________ Date: ______________________