Pediatric New Patient

Patient Name: _____

Parent/Guardian information:

Parents Names: _____
Street Address: _____
City/State: _____ Zip: _____

Home #: _____ Cell #: _____
Work/Other #: _____

Parent email: _____
Parent Employer/occupation: _____

Marital status: M S D W Name of spouse (if applicable): _____
Other children (names/ages): _____

How did you hear about our office? _____

Child information:

Patient full name: _____

Birthdate: _____ Date of last physical: _____
Purpose of this visit: _____
_____
How long has problem lasted? _____
When/how did it start? _____
What have you done for problem that hasn't worked? _____
What helps? _____
How does the problem limit child's activities: _____
What makes problem worse? _____
Is the problem? _____constant _____occasional _____intermittent _____cyclical

Have there been any major events of trauma or notable disease in your child's life? _____
_____
Has your child had previous chiropractic care? (please share any details that would be helpful for our treatment protocol....likes/dislikes etc...) _____

Current medications? _____
Hospital stays or surgeries? _____
Vaccination reactions? _____

Anything else we should know about your child that could relate to the care they receive at our office?
_____
_____

Answer ANY/ALL of below that apply:

1) Tell me about your pregnancy:

~Was it easy for you to get pregnant? Y N details about your journey:
_____
_____
_____

~Did you have an ultrasound? Y N If so, how many?_____

~What other testing/procedures did you undergo while pregnant?_____
_____

~Did you carry baby full term? Y N details:_____

~Was there stress during pregnancy? Y N details:_____

~Did you maintain a healthy lifestyle during the pregnancy (tell me about any and all drinking, smoking, recreational or prescription drug use, exercise, diet, prenatal vitamins)? details:_____
_____

~Was your baby ever in the breech or occiput posterior position? Y N details:_____

~Tell me any complications that occurred:_____

2) Tell me about the birth of your child:

————-midwife ————OB ————-doula ————birth center ————hospital ————home

Did you: _____deliver vaginally _____ have a c-section _____ use forceps _____vacuum extraction

Were you: _____induced _____given an epidural

Was it a difficult birth? _____

Length of labor:_____ Was excessive force used?_____

Did you tear & to what degree?_____ Episiotomy?_____

Was baby's position normal for delivery?_____

How was baby after delivery (APGARS or other notable occurrences):_____

_____

3) Tell me more:

Did you breastfeed? _____ How soon after birth? _____ What duration?_____

Tell me any issues you had:_____

Did you use formula?_____ If so, were there any issues?_____

When was solid food introduced?_____

Did your child have any problems / sensitivities / allergies with food?_____

Did your child suffer from colic or reflux?_____

***4) As a baby/toddler (birth to age 4)** , did any of the following happen?*

_____significant fall (changing table, crib, furniture, playground equipment, etc) _____tumble down stairs

____car accident ____play in "johnny jumper" _____ear infections ____tonsilitis ____reaction to vaccination

____frequent nosebleeds ____problems feeding ____frequent crying spells ____frequent diarrhea ____constipation

____sleeping problems _____frequent colds _____didn't gain weight ____allergies ____skin problems

____breathing problems ____developmental delays ____behavioral difficulties ____other of note

~Please explain any of the above more thoroughly:_____

_____

***5) As a young child or adolescent**, did any of the following occur?*

____broken bones _____dizziness ____significant falls ____car accidents other accidents ____bed wetting ____asthma

____allergies ____hyperactivity ____spectrum disorder ____learning difficulties ____leg/knee pain ____sports accident

____stomach pains ____scoliosis or other spinal issue ____headaches ____excessive stress _____fatigue

_____neck pain ____back pain ____weight gain/loss _____foot/ankle pain ____arm/wrist pain _____tingling/numbness

____ear infections ____weakened immunity ____heart/cardiovascular issues ____joint pain ____muscle spasm/weakness

____frequent colds ____frequent sinus problems ____other of note

post pubescent girls: menstrual irregularities or problems_____

*~Please explain any of the above more thoroughly **or add additional concerns**:_____*

_____

_____

Signature of parent or Guardian_____ Date:_____