PEDIATRIC NEW PATIENT INFORMATION

Date: _____

PATIENT INFORMATION:

Child's Name: _____ Child's Nickname: _____

Reason for Visit: _____

Sex: M / F Date of Birth: _____ Age: _____

Home Phone#: _____ Cell Phone#: _____

Child's Home Address: _____

Who may we thank for referring you? _____

FAMILY INFORMATION

Parent 1: _____ Parent 2: _____

Home Phone #: _____ Home Phone #: _____

Cell Phone #: _____ Cell Phone #: _____

Parent's Marital Status: Married _____ Single: _____ Divorced: _____ Widowed: _____

List Age of Other Children in Family: _____

Predominant language used at home: _____

PAYMENT INFORMATION

Please read and sign our Financial Agreement. Does your health insurance cover chiropractic? Y / N
If you have insurance that may cover chiropractic services, please provide your current insurance card so that we may make a copy. Additionally, please enter the following information relating to the person who is responsible for the child's health insurance coverage.

Insured's Name: _____ Date of Birth of Insured: _____

Insurance Company Name: _____ Phone #: _____

Insurance Company Address to send claims: _____

Employer: _____ Group #: _____ Insured ID#: _____

CONSENT TO TREAT

Being the parent or legal guardian of this child, I hereby authorize the office and its doctors to examine and administer care to my son / daughter name _____ as the examining / treating doctor deems necessary.

I understand and agree that I am personally responsible for payments of all fees charged by this office for such care.

Parent's Name: _____ Signature: _____

Date: _____ Witness by: _____

PREGNANCY HISTORY

Today's Date: _____

Child's Name: _____ Sex: M / F Date of Birth: _____ Age: _____

Mother's Name: _____ How many children do you have? _____

What was the term of your pregnancy? _____ Weeks

DURING YOUR PREGNANCY, DI YOU HAVE ANY OF THE FOLLOWING?

	Yes	No	
Falls?	____	____	_____
Motor Vehicle Accidents?	____	____	_____
Near-Miss MVA	____	____	_____
High B/P?	____	____	_____
Diabetes?	____	____	_____
Anemia?	____	____	_____
Morning Sickness?	____	____	_____
Indigestion?	____	____	_____
Seizures?	____	____	_____
Swollen Ankles?	____	____	_____
Thyroid Problems?	____	____	_____
Heart Problems?	____	____	_____
Back Pain?	____	____	_____
Abnormal Bleeding?	____	____	_____
Were you hospitalized?	____	____	_____
Any other Illnesses?	____	____	_____
Had DTAP Vaccine?	____	____	_____
Had Flu Shot?	____	____	_____
How Many Ultrasounds?	____	____	_____

DURING YOUR PREGNANCY, DID YOU USE ANY OF THE FOLLOWING?

	Yes	No	
Tobacco?	____	____	_____
Alcohol?	____	____	_____
Prescription Drugs?	____	____	_____
Over-The-Counter Meds?	____	____	_____
Recreational Drugs?	____	____	_____

BIRTH HISTORY

Today's Date: _____

Child's Name: _____

LABOR AND DELIVERY

How long was the labor from the regular contractions to the birth? _____ hours

How long was the (pushing phase) of the labor? _____ hours

	Yes	No	
Hospital Birth	____	____	_____
Home Birth	____	____	_____
Midwife Assisted	____	____	_____
Vaginal Delivery	____	____	_____
Planned C-Section	____	____	_____
Emergency C-Section	____	____	_____
Was Birth Induced (Pitocin)	____	____	_____
Forceps Extraction	____	____	_____
Vacuum Extraction	____	____	_____
Anesthesia Administered	____	____	_____
Fetal Distress	____	____	_____
Meconium Staining	____	____	_____
Cord Wrapped Around Neck	____	____	_____
Head Presentation	____	____	_____
Face Presentation	____	____	_____
Breech Presentation	____	____	_____

BABY'S CONDITION IMMEDIATELY AFTER BIRTH

Apgar Scores: At 1 Minute ____/10 At 5 Minutes _____/10

Baby's Crying Baby Cried Immediately After Birth __ Cried Strongly __ Weak Cry __ Didn't Cry for __ Mins.

Baby's Color Pink All Over ____ Blue Face ____ Blue Hands/Feet ____

Baby's Activity Arms and Legs Actively Moving _____ Floppy Baby _____

Intensive Care Was Required ____ Days in Neonatal Intensive Care Unit ____

Medication Given at Birth: _____ Vaccines Administered _____

Birth Weight _____ lbs./kg Birth Length _____ ins/cms Baby Home on Day ___

DEVELOPMENTAL MILESTONES

Today's Date: _____

Child's Name: _____ Sex: M / F DOB: _____ Age: ____

Please Indicate the most complex skill that your child can perform in each section
In each section, the tasks are arranged in order of increasing developmental age.

GROSS MOTOR SKILLS

___ Able to hold head up from the table momentarily
___ Head and shoulder can be supported by the forearms
___ Infant can be pulled up into a sitting position by the hands
___ Sits unsupported in the upright position
___ Head and shoulders can be supported by the arms
___ Rolls from prone to supine position
___ Crawls
___ Sands holding onto furniture
___ Walks with someone holding onto one hand
___ Walks unassisted
___ Runs
___ Negotiates stairs placing 2 feet on each step
___ Climbs stairs using one foot on each step
___ Walks down stairs with one foot on each step
___ Hops on one foot

SOCIAL SKILLS

___ Smiles
___ Reaches for familiar objects
___ Plays with hands
___ Plays with feet
___ Clearly shows joy and pleasure
___ Feeds self with fingers
___ Plays peek-a-boo
___ Understands yes and no

FINE MOTOR SKILLS

__ Primitive grasp reflex present
___ Holds and shakes a rattle placed in the hand
___ Grasps objects independently
___ Moves an object from one hand to the other
___ Self-Feeding, can hold and eat a cookie
___ Checks objects by placing them in the mouth
___ Picks up object with thumb and index finger
___ Turns 2 to 3 pages of a book at a time
___ Turns pages of a book one at a time
___ Builds a tower containing at least 5 blocks
___ Builds at tower containing at least 10 blocks

COMMUNICATION SKILLS

___ Makes cooing sounds
___ Laughs
___ Uses one syllable words such as "da"
___ Uses 2 syllable words such as "dada"
___ Uses 2 to 3-word vocabulary
___ Uses 2 to 3-word phrases

ADAPTIVE SKILLS

___ Holds own bottle
___ Feeds from cup unassisted
___ Feeds self with utensils
___ Able to identify and match some colors
___ Copies a circle
___ Copies a cross

NEWBORN HISTORY

Birth to 2 Months

Today's Date: _____

Child's Name: _____ Sex: M / F Date of Birth: _____ Age: _____

The following questions are designed to help the doctor provide the best possible spinal care for your child.

How many hours does your baby sleep between feeds? During Day: _____ At Night: _____

	Yes	No	
Does your baby go to sleep easily?	___	___	_____
Does your baby have a preferred sleeping position?	___	___	_____
Does baby cry if you change the sleeping position?	___	___	_____
Does baby have any feeding difficulties?	___	___	_____
Is baby being breast fed? (if No for how long)	___	___	_____
Does baby have a one-sided breast-feeding preference?	___	___	_____
Is baby formula fed? (Which formula or other milk source)	___	___	_____
Does baby frequently spit-up after feeding?	___	___	_____
Does baby cry a lot? For how many hours each day?	___	___	_____
Does baby pass a lot intestinal gas?	___	___	_____
Does baby have a preferred head position?	___	___	_____
Does baby frequently arch his/ her head & neck backwards?	___	___	_____
Does baby cry or become irritable during diaper change?	___	___	_____
Has baby ever had a fever?	___	___	_____
Has baby had any falls?	___	___	_____
Has baby been in a car accident or near miss?	___	___	_____
Has baby had any other trauma?	___	___	_____
Has your baby been vaccinated?	___	___	_____
Do you have any concerns you wish to discuss?	___	___	_____