Pediatric New Patient Form

Personal Information

Childs Name: _____ Parent(s)/Guardian(s) Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Is it ok to call you at work? Yes / No

Date of Birth: _____ Age: _____ Sex: ☐ Male ☐ Female

Childs Social Security Number: _____ Email: _____

Would you like to be on our email newsletter list? Y / N

How did you hear about our office? _____

Has your child ever had Chiropractic care before? Yes / No

If yes, please tell us the doctor's name _____

Were you pleased with your care? Yes / No

Is your child receiving care from another health professional? Yes / No

If yes, please name them and their specialty _____

_____

Who is your family's primary care physician? _____

Please list any drugs or medications your child is taking _____

_____

List any vitamins/herbs/homeopathic your child is taking _____

_____

Please list any allergies your child has _____

Instructions

Throughout today's exam, your doctor will be searching for one thing: the CAUSE of your child's health challenge. Chiropractic wellness care seeks to find the cause of a health challenge, rather than simply tying to artificially alleviate the symptoms through chemical manipulation. The following questions are vital to finding the cause of your current health condition and finding the cause of your child's current health condition and finding solutions to your child's health challenge. Please take your time answering these questions, including anything that you may feel is related to your child's current complaints. At Infinite Health Chiropractic, we have set the bar high and expect nothing but the best results for your child. In order to properly begin that process, having a detailed history is a must, so if necessary please use an additional sheet of paper to answer these questions.

Questions

If possible, please fill out thoroughly and complete all forms and submit to Infinite Health Chiropractic for review at least 24 hours prior to the day your initial exam is scheduled.

How would you rate your child's current health status? Excellent / Good / Average / Poor

Where would you like your child's health to be? Excellent / Good / Average / Poor

What health challenge brings your child to our office? _____

_____

When did the symptoms first begin? _____

Did the problem start: ☐Suddenly ☐Gradually ☐Post-Injury

Is the health challenge: ☐Improving ☐Getting Worse ☐Staying the Same ☐Constant ☐Intermittent

What makes the problem better? _____

What makes the problem worse? _____

Has your child ever had a similar condition? Yes / No

Please explain _____

Have you been treated for this condition before? Yes / No

Please explain _____

Does your child eat well? Yes / No

Does your child have regular bowel / bladder movements? Yes / NO

How do you feel your child's present health challenge affects his/her overall health and ability to experience an optimal quality of life? _____

How would your/your child's life be different if he/she no longer experienced this health challenge? _____

_____

How would you describe your child's overall health status prior to this present health challenge?

_____

Other than today's presenting complaint, please list any and all concerns regarding your child's health. _____

What is your medical provider's plan for your child to experience optimal health and wellness?

_____

What is the cause of your child's health challenge? _____

Goals

What are your primary health goals for your child?

_____

_____

Current height: _____ Current weight: _____

Please list all Hospitalizations/Surgical History and the year

_____

_____

Health History

Child was conceived: ☐Naturally ☐Fertility Treatment ☐In-Vitro

Childs birth was: ☐At Home ☐At a Birthing Center ☐At a Hospital

My obstetrician / midwife / family physician was _____

Child's birth was: ☐Natural Vaginal (no medication or interventions)

☐Vaginal with Interventions

☐Induction ☐Pain Medication ☐Epidural ☐Episiotomy

☐Vacuum Extraction ☐Forceps ☐Other

☐C-Section

☐Scheduled ☐Emergency

Please list reasons for any interventions/complications _____

_____

Child's birth weight _____ Child's birth height _____ Current weight _____

Current height _____ APGAR score at birth _____ APGAR score after 5 minutes _____

Family History:

___Arthritis (Parent or Sibling) ___Cancer (Parent or Sibling) ___Cholesterol (Parent or Sibling)

___Diabetes (Parent or Sibling ___Psychiatric (Parent or Sibling) ___Stroke (Parent or Sibling)

___Thyroid (Parent or Sibling) ___Hear problems (Parent or Sibling)

___High blood Pressure (Parent or Sibling)

Siblings: name and age

_____

_____

Growth & Development

Was your child alert and responsive within 12 hours of delivery? Yes / No

If no, please explain _____

At what age did your child: Respond to sound _____ Follow an object _____

Hold head up _____ Vocalize _____ Sit alone _____ Teethe _____

Crawl _____ Walk _____

Is/was your child breastfed? Yes / NO If yes, how long? _____

Formula introduced at age _____ What type _____

Introduction of cow's milk at age _____ Began solid foods at age _____

Please list any food / juice intolerance _____

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 and include treatment / medications / supplements _____

_____

List any drugs / medications (including over the counter) taken during pregnancy _____

_____

List any supplements taken during pregnancy _____

Any exposure to ultrasound? Yes / No If so, how many and what was the medical reason? _____

_____

Any smokers at home? Yes / No

Has your child received any vaccines? Yes / No If yes, which vaccines were received and list the reactions _____

_____

Has your child received any antibiotics? Yes / No If yes, how many times and list reason _____

_____

Any difficulty with breastfeeding? Yes / No If yes, please explain _____

_____

Any difficulty with bonding? Yes / No If yes, please explain_____

_____

Any behavioral problems? Yes / No If yes, please explain _____

_____

Any night terrors, sleepwalking or difficulty sleeping? Yes / No

If yes, please explain _____

Age child began daycare _____ Average number of hours of TV per week _____

Does your child seem normal for their age? Yes / No If no, please explain _____

_____

Family History Review

Check those involving immediate family and add identification: M=Mother, F=Father; S=Sibling; G=Grandparents

☐Cancer, type _____
☐M ☐F ☐S ☐G

☐Depression
☐M ☐F ☐S ☐G

☐Diabetes
☐M ☐F ☐S ☐G

☐Back Problems
☐M ☐F ☐S ☐G

☐Heart Disease
☐M ☐F ☐S ☐G

☐Liver Disease
☐M ☐F ☐S ☐G

☐High Blood Pressure
☐M ☐F ☐S ☐G

☐High Cholesterol
☐M ☐F ☐S ☐G

☐Lung Problems
☐M ☐F ☐S ☐G

☐Scoliosis
☐M ☐F ☐S ☐G

☐Neck Problems
☐M ☐F ☐S ☐G

☐Osteoporosis
☐M ☐F ☐S ☐G

☐Seizures
☐M ☐F ☐S ☐G

☐Osteoarthritis
☐M ☐F ☐S ☐G

☐Rheumatoid Arthritis
☐M ☐F ☐S ☐G

☐Other _____

Has your child ever been checked for vertebral subluxation? Yes / No

Do any of your friends or relatives see a chiropractor? Yes / No

If yes, do they use chiropractic for ☐Health Maintenance / Optimization ☐Health Problems ☐Both

Are you seeking chiropractic for ☐Health Maintenance / Optimization ☐Health Problems ☐Both

What would you like to gain from chiropractic? _____

_____

Are there other health concerns or anything else you'd like us to know about your child? _____

_____

_____

Does your child suffer from:

☐Ear Infections
☐Trouble Focusing
☐Textures Irritate
☐Headaches
☐Hyperactivity
☐Reflux
☐Flimsy Body
☐Stutter
☐Bed Wetting
☐Anxiety/Fear
☐GI Issues
☐Seizures
☐Fevers
☐Asthma
☐Acne
☐Constipation or Diarrhea
☐Head Banging
☐No/Lack of Eye Contact
☐Allergies
☐Colic
☐Stiff Body
☐Skin Lesions

☐Other: _____

What makes your child comfortable/at ease? _____

Do you use any support groups? _____

Stress in our lives can cause vertebral subluxations. Please indicate which of the following stressors have you experienced in your child's life.

Physical / Chemical / Emotional Stress			**Comments:**
Trauma at Birth	☐Yes	☐No	
Slips / Falls	☐Yes	☐No	
Car Accidents	☐Yes	☐No	
Poor Posture	☐Yes	☐No	
Sports Injuries	☐Yes	☐No	
Excessive Computer/TV Time	☐Yes	☐No	
Sleeping on Belly	☐Yes	☐No	
Carrying Heavy Backpack	☐Yes	☐No	
Eating Fast food weekly	☐Yes	☐No	
Eating Pre-Packaged Food Weekly	☐Yes	☐No	
Daily Caffeine Intake	☐Yes	☐No	
Vaccinations/Immunizations	☐Yes	☐No	
Medication/Antibiotic Use	☐Yes	☐No	
Smoking/2nd Hand Smoke	☐Yes	☐No	
Family Stress	☐Yes	☐No	
Death of a Loved One	☐Yes	☐No	
Negative Self-Talk/Thoughts	☐Yes	☐No	
Feeling Pressure	☐Yes	☐No	
Feeling Fear	☐Yes	☐No	

When a person seeks chiropractic care, it is essential for the individual and chiropractor to be working towards the same objective. It is not our goal or intention to treat or cure any specific symptom or disease. In this office, we provide specific chiropractic adjustments to relieve the body of stress, allowing it to function at its optimal level. Chiropractic is not a substitute for medicine; it instead facilities healing from within. If we find that you are ineligible for care, we will refer you to a proper health care provider.

I have completed the above forms to the best of my ability and understand the above statements. I agree to accept care in the office on this basis.

Signature: _____ Date: _____