NEW PATIENT FORM
PEDIATRIC 3-12 YEARS

CHILD INFO

FIRST NAME		LAST NAME	
DATE OF BIRTH	AGE	SEX ○ M ○ F	
ADDRESS	CITY	STATE	ZIP
PARENT EMAIL ADDRESS			
WHICH COMMUNICATION DO YOU PREFER FOR APPOINTMENT REMINDERS? ○ TELEPHONE CALL ○ TEXT MESSAGE ○ E-MAIL ○ ANY IS ACCEPTABLE			
MOTHER'S NAME		MOTHER'S PHONE	
FATHER'S NAME		FATHER'S PHONE	

CURRENT COMPLAINTS

REASON FOR YOUR VISIT TODAY	
DATE IF INJURY	DATE SYMPTOMS APPEARED
HAS YOUR CHILD EVER HAD THE SAME CONDITION? ○N ○Y	IF YES, WHEN?
LIST OTHER PRACTITIONERS SEEN FOR THIS COMPLAINT	
HAS YOUR CHILD EVER BEEN UNDER CHIROPRACTIC CARE? ○ N ○ Y	IF YES, WHEN?
HAS THERE BEEN ANY CHANGES IN YOUR CHILD'S BEHAVIOR? ○N ○Y	IF YES, WHEN?
PLEASE CHECK IF YOUR CHILD HAS EXPERIENCED OF THESE CHANGES IN BEHAVIOR: ○ BOWEL MOVEMENTS ○ FUSSINESS ○ CRYING ○ LOSS OF SLEEP ○ WON'T EAT ○ LETHARGIC ○ RASH ○ MOOD SWINGS	
IF YOUR CHILD HAS PAIN, IS IT? ○ SHARP ○ DULL ○ CONSTANT ○ INTERMITTENT ○ TRAVELING ○ RADIATING ○ MILD ○ MODERATE ○ SEVERE ○ INTOLERABLE	
WHAT MAKES YOUR CHILD FEEL BETTER?	WORSE?

PLEASE INDICATE THE TYPE AND LOCATION OF THE SYMPTOMS YOUR CHILD IS CURRENTLY EXPERIENCING

A=ACHE
B=BURNING
N=NUMBNESS
P=PINS AND NEEDLES
S=STABBING
T=TINGLING
O=OTHER

IF OTHER,
WHAT DOES IT FEEL LIKE?

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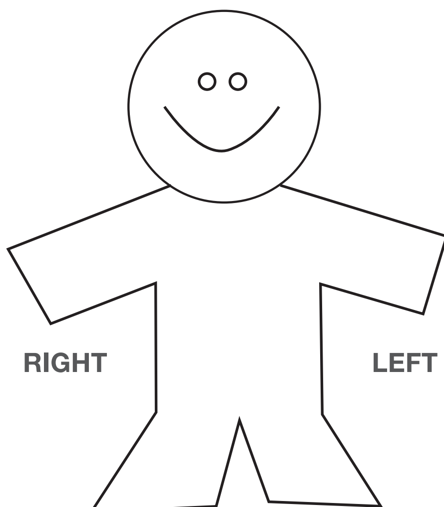

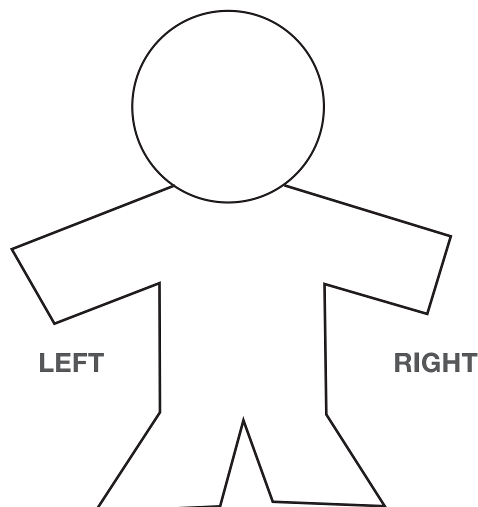

MEDICAL HISTORY

HAS YOUR CHILD BEEN TREATED FOR ANY CONDITIONS IN THE LAST YEAR? ○N ○Y IF YES, PLEASE DESCRIBE
DATE OF LAST PHYSICAL EXAM HAVE X-RAYS BEEN TAKEN? ○N ○Y
DOES YOUR CHILD HAVE ANY KNOWN ALLERGIES? ○N ○Y IF YES, PLEASE DESCRIBE
NUMBER OF BOWEL MOVEMENTS A DAY HOURS OF SLEEP PER NIGHT
DOES YOUR CHILD HAVE ANY DEVELOPMENTAL DISORDERS OR CHALLENGES? ○N ○Y IF YES, PLEASE DESCRIBE
WAS YOUR CHILD ○BREAST-FED? ○FORMULA-FED? HOW LONG?
PLEASE CHECK IF THE MOTHER PARTICIPATED IN ANY OF THE FOLLOWING DURING PREGNANCY: ○ SMOKING ○ALCOHOL ○PRESCRIPTIONS ○OVER-THE-COUNTER MEDICATIONS ○ PRENATAL VITAMINS ○ SUPPLEMENTS
WERE THERE ANY COMPLICATIONS WITH PREGNANCY OR DELIVERY? ○N ○Y IF YES, PLEASE DESCRIBE
WHAT MEDICATIONS IS YOUR CHILD CURRENTLY TAKING? (INCLUDE DOSAGE & FREQUENCY)
WHAT VITAMINS, MINERALS OR HERBS IS YOUR CHILD CURRENTLY TAKING? (DOSAGE & FREQUENCY)
HAS YOUR CHILD BEEN INVOLVED IN ANY AUTOMOBILE ACCIDENTS? ○N ○Y IF YES, PLEASE DESCRIBE
PLEASE LIST ALL OF YOUR CHILD'S ROUTINE SPORTS/RECREATIONAL ACTIVITIES

PLEASE LIST ANY INJURIES (BROKEN BONES, CONCUSSIONS, ETC.)

HAS YOUR CHILD EVER SUFFERED FROM ANY OF THE FOLLOWING	IF YES, PLEASE DESCRIBE
○ ASTHMA ○ ALLERGIES ○ HYPERACTIVITY ○ BED WETTING ○ EAR INFECTIONS ○ SKIN PROBLEMS ○ DIFFICULTY SLEEPING ○ COLIC ○ CONSTIPATION ○ DIARRHEA ○ NUTRITIONAL DEFICIENCIES ○ INSUFFICIENT PHYSICAL ACTIVITY ○ HEADACHES ○ TROUBLE WALKING ○ FREQUENT COLDS ○ FREQUENT FALLS ○ TROUBLE TURNING HEAD SIDE-TO-SIDE ○ TROUBLE MOVING HEAD UP AND DOWN ○ BACK ACHES ○ OTHER	

FAMILY HISTORY

PLEASE LIST PRESENT AND PAST HEALTH CONDITIONS SUFFERED BY FAMILY MEMBER