



NEW DIRECTIONS
CHIROPRACTIC

NEW PATIENT FORM

PEDIATRIC 0-2 YEARS

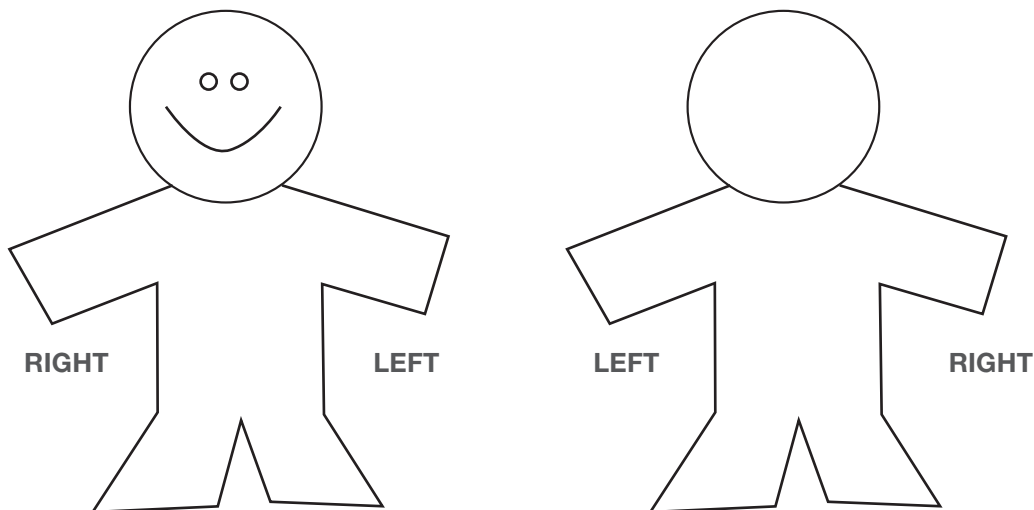
CHILD INFO

FIRST NAME		LAST NAME	
DATE OF BIRTH	AGE	SEX <input type="radio"/> M <input type="radio"/> F	
ADDRESS	CITY	STATE	ZIP
PARENT EMAIL ADDRESS			
WHICH COMMUNICATION DO YOU PREFER FOR APPOINTMENT REMINDERS? <input type="radio"/> TELEPHONE CALL <input type="radio"/> TEXT MESSAGE <input type="radio"/> E-MAIL <input type="radio"/> 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? <input type="radio"/> N <input type="radio"/> Y IF YES, WHEN?	
LIST OTHER PRACTITIONERS SEEN FOR THIS COMPLAINT	
HAS YOUR CHILD EVER BEEN UNDER CHIROPRACTIC CARE? <input type="radio"/> N <input type="radio"/> Y IF YES, WHEN?	
HAS THERE BEEN ANY CHANGES IN YOUR CHILD'S BEHAVIOR? <input type="radio"/> N <input type="radio"/> Y IF YES, WHEN?	
PLEASE CHECK IF YOUR CHILD HAS EXPERIENCED OF THESE CHANGES IN BEHAVIOR: <input type="radio"/> BOWEL MOVEMENTS <input type="radio"/> FUSSINESS <input type="radio"/> CRYING <input type="radio"/> LOSS OF SLEEP <input type="radio"/> WON'T EAT <input type="radio"/> LETHARGIC <input type="radio"/> RASH <input type="radio"/> MOOD SWINGS	
WHAT MAKES YOUR CHILD FEEL BETTER?	WORSE?

PLEASE INDICATE THE LOCATION OF ANY DISCOMFORT OR CHANGES IN APPEARANCE YOUR CHILD IS CURRENTLY EXPERIENCING



MEDICAL HISTORY

HAS YOUR CHILD BEEN TREATED FOR ANY CONDITIONS IN THE LAST YEAR? <input type="radio"/> N <input type="radio"/> Y IF YES, PLEASE DESCRIBE	
DATE OF LAST PHYSICAL EXAM	HAVE X-RAYS BEEN TAKEN? <input type="radio"/> N <input type="radio"/> Y
DOES YOUR CHILD HAVE ANY KNOWN ALLERGIES? <input type="radio"/> N <input type="radio"/> 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? <input type="radio"/> N <input type="radio"/> Y IF YES, PLEASE DESCRIBE	
WAS YOUR CHILD <input type="radio"/> BREAST-FED? <input type="radio"/> FORMULA-FED? HOW LONG?	
TYPE OF DELIVERY? <input type="radio"/> VAGINAL <input type="radio"/> FORCEPS <input type="radio"/> C-SECTION <input type="radio"/> SUCTION OR VACUUM	
PLEASE CHECK IF THE MOTHER PARTICIPATED IN ANY OF THE FOLLOWING DURING PREGNANCY: <input type="radio"/> SMOKING <input type="radio"/> ALCOHOL <input type="radio"/> PRESCRIPTIONS <input type="radio"/> OVER-THE-COUNTER MEDICATIONS <input type="radio"/> PRENATAL VITAMINS <input type="radio"/> SUPPLEMENTS	
WERE THERE ANY COMPLICATIONS WITH PREGNANCY OR DELIVERY? <input type="radio"/> N <input type="radio"/> 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? <input type="radio"/> N <input type="radio"/> Y IF YES, PLEASE DESCRIBE	

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