

PEDIATRIC NEW PATIENT INFORMATION

Today's Date: _____

PATIENT INFORMATION

Child's First Name: _____ Last Name: _____

Reason for Visit: _____

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

Home Phone #: _____

Home Address: _____

Who may we thank for referring you? _____

FAMILY INFORMATION

Mother's Name: _____ Father's Name: _____

Does one or both parents have custody? _____

Home Phone #: _____ Home Phone #: _____

Work Phone #: _____ Work Phone #: _____

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

List Ages of Other Children in Family: _____

PAYMENT INFORMATION

Please read and sign our Financial Agreement. Does your health insurance cover chiropractic? Y / N

If you have health insurance that may cover chiropractic care, 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: _____ DOB: _____ SS#: _____

Insurance Company Name: _____ Phone #: _____

Insurance Company address to send claims: _____

Employer: _____ Group # _____ Insured's ID #: _____

CONSENT FOR CHIROPRACTIC CARE

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

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

Guardian's Name (Printed) _____

Guardian Signature: _____

Date: _____ Witnessed by: _____

PEDIATRIC HISTORY

ANSWER THE QUESTIONS THAT APPLY TO THE GROWTH AND DEVELOPMENT OF YOUR CHILD.

- Yes No Was this child born at home?
- Were forceps or a vacuum extractor used? C-Section delivery? _____ Breech delivery? _____
- Can your child sit unsupported?
- Is your child crawling yet?
- Is your child walking yet? At what age did your child start to walk? _____ Months
- Have you noticed a foot turned in or out? _____
- Do you have any other concerns about your child's growth & development? _____

HEALTH HISTORY

- Yes No Has your child any health problems? Infections? _____
- Has your child had any other illnesses? _____
- Is your child presently receiving any medications? _____
- Has your child recently been vaccinated? _____ Any Reactions? _____

FAMILY HISTORY

- Do you have a family history of:
- Yes No Heart trouble
 - Cancer
 - Nervous conditions
 - Depression
 - Inherited disease
- Explain _____

LIFE STYLE INFORMATION

- DIET**
 Breast feeding this child? _____ Are you bottle feeding this child? _____
 What is his/her favorite food? _____ What foods does she/he dislike? _____

SLEEPING HABITS

- Any problems with bed-time? _____
 What position does he/ she sleep in? _____ Hours total _____

Parent/ Guardian Signature _____ Date _____

EXAMINATION INFANT

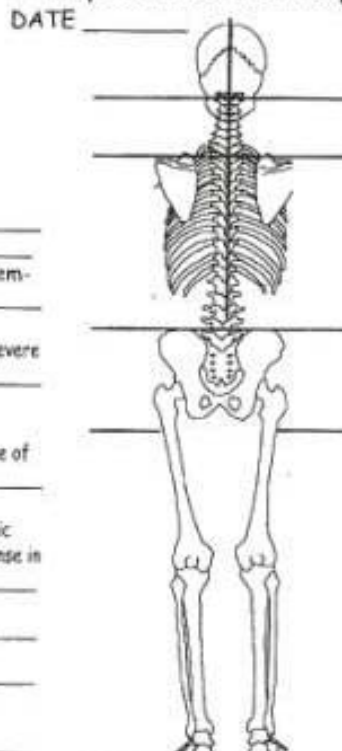
- Cry _____
- Skin color, tone _____
- Size (weight WNL or below?) _____
- Body proportions _____
- Nutritional status _____
- Symmetry _____

NERVOUS SYSTEM

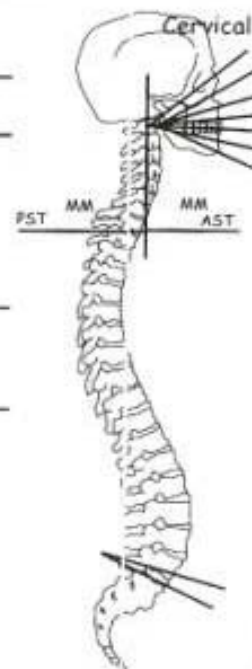
- Joint ROM**
 Normal _____
 Spasticity/ Flaccidity _____
 Gentle stroking should produce movement or withdrawal of extremity or facial expression. Findings: _____
- Rooting Reflex** (Disappears at 3/4 months. Absence before is indicative of severe generalized or central nervous system disease). Findings: _____
- Galant's Reflex** (Disappears at 2 months. Transverse cord lesions may be detected using this reflex) Stroke along paravertebral line. Should produce curve of trunk towards stimulated side. Finding: _____
- Moro sign** (Startle reflex. Persistence beyond 4 months may indicate neurologic disease. Low spinal injury & dislocation of the hip may produce absence of response in one or both legs). Findings: _____
- Babinski response** (abnormal beyond age 2). Findings: _____
- Ortolani's test** (hip click). Findings: _____
- Grasp reflex** (persistence beyond 4 mo. suggests cerebral dysfunction). Findings: _____

CHIROPRACTIC EXAMINATION

Palpation/Posture Analysis



Radiographic/Posture Study



Skull Position
 Anterior Translation (AST) _____ MM
 Posterior Translation (PST) _____ MM

Cervical Curve
 Normal _____
 Hypolordosis _____
 Hyperlordosis _____

Thoracic Spine
 A-P _____
 Lateral _____

Lumbar Spine
 A-P _____
 Lateral _____

Pelvis
 A-P _____
 Greater Trochanters (RT) _____
 (LT) _____

Comments _____

DATE _____

PEDIATRIC HISTORY

Child _____ Age _____ Sex _____ Date _____
Mother _____ Father _____ Siblings _____

1. Chief Complaint (onset, location, quality, DIF, exac/remis, tx hx)

2. Prenatal Health (pregnancy complications, full term, labor & delivery, special procedures, birth date)

3. Neonatal Health (birth wt/ht, APGAR, spontaneous resp., complications, nursery stay)

4. Nutritional Hx (breast vs. bottle, feeding sched, meds/vit./fluoride, appetite & attitude, stools)

5. Growth & Development (sleep pattern, age of head control/smile/sitting/standing/walking/teeth/vocaliz.)

6. Medical Survey/Other (immunizations, illnesses)
