

**New Patient Information
PEDIATRIC**

Today's date: _____

Please complete the following information

Child's name: _____
 Parent's name: _____
 Address: _____
 Home number: _____
 Work number: _____
 Where do you prefer we call? _____
 Birth date: _____
 Previous chiropractor: _____

Birth history

Labor and Delivery: Easy Moderate Difficult
 Type of delivery: Vaginal delivery C-section Forceps/vacuum extraction

Regarding your child today

	Yes	No
Is your child accident prone?.....	<input type="checkbox"/>	<input type="checkbox"/>
Has your child had any falls down steps?.....	<input type="checkbox"/>	<input type="checkbox"/>
Has your child ever been involved in a motor vehicle accident?.....	<input type="checkbox"/>	<input type="checkbox"/>
Has your child ever been hospitalized or had surgery?.....	<input type="checkbox"/>	<input type="checkbox"/>
Has your child ever had any broken bones or sprain injuries?.....	<input type="checkbox"/>	<input type="checkbox"/>

How does this affect your child's life?

Restricted in daily activities Excessive appetite or thirst
 Hindering ability to exercise or to participate in sports and activities
 Poor posture during reading, watching TV, working on a computer

How long has your child been living this way? Weeks Months Years

Would you like to find the cause of your child's problem(s)?
 Yes No Maybe

If so, what results would you want for your child?

Does your child experience any of these health problems?

<input type="checkbox"/> Headaches	<input type="checkbox"/> Learning disorder	<input type="checkbox"/> Ear infections	<input type="checkbox"/> Ear problems
<input type="checkbox"/> Menstrual problems	<input type="checkbox"/> Breathing problems	<input type="checkbox"/> Irritability	<input type="checkbox"/> Sinus pain/allergies
<input type="checkbox"/> Sleeping problems	<input type="checkbox"/> Underactive	<input type="checkbox"/> Asthma	<input type="checkbox"/> Eating disorder
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Stomach problems	<input type="checkbox"/> Digestive trouble	<input type="checkbox"/> Hyperactivity
<input type="checkbox"/> Frequent colds	<input type="checkbox"/> Frequent flus	<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Acne/rashes
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Constipation		

Current health problems: _____

Currently taking medications: _____

I understand and agree that health insurance is an agreement between the carrier and myself. I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate care, any fees for professional services rendered to me will be immediately due and payable.

Parent or guardian signature authorizing care

Parent/guardian signature: _____

Date: _____

Social security number: _____

Acknowledgement of HIPPA Privacy Act

My signature acknowledges I have read and understand the HIPPA Act.

Signature: _____ Date: _____

Personal representative name printed: _____

Personal representative signature: _____

Relationship to patient: _____ Date: _____

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our office. If a claim is submitted to Medicare/Insurance, your health information on this form may be shared with Medicare/Insurance. Your health information which Medicare/Insurance sees will be confidential.