Pediatric New Patient Packet

Pediatric New Patient Form

1. Patient Information

Child's Name: ____________________ Nickname: ____________________

Reason for visit: ____________________

Date of Birth: ____________________ Gender: ○ Female ○ Male Age: ____________________ Grade in School: ____________________

Home Phone: ____________________ Parent's Email: ____________________

Home Address: ____________________ Apt./Unit #: ____________________ City: ____________________ State: ____________________ Zip Code: ____________________

How were you referred to our office? ____________________

2. Family Information

Mother’s Name: ____________________ Home Phone #: ____________________

Cell Phone #: ____________________

3. Father’s Name: ____________________ Home Phone #: ____________________

Cell Phone #: ____________________

4. Parent’s Marital Status:

○ M ○ S
○ W ○ D

5. Child lives with: ____________________

List ages of other children in family: ____________________ Predominant language spoken at home: ____________________

6. CONSENT TO TREAT & AUTHORIZATION TO PAY AND RELEASE OF INFORMATION

Being the parent or legal guardian of this minor child, I hereby authorize this office and its doctors to examine and administer care to my son/daughter as the examining/treating doctor deems necessary. I agree that I am personally responsible for all fees charged by this office for such care.

Parent/Guardian

______________________________ Signature

______________ Date

Child History

7. Reason for today's visit:

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8. Does your child complain of pain or discomfort? If yes, when did it begin?

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9. Was the onset

- ☐ Sudden
- ☐ Gradual
- ☐ Constant
- ☐ Intermittent

10. Has your child ever had this problem before?

- ○ Yes
- ○ No

11. Has your child previously been treated for this problem?

- ○ Yes
- ○ No

12. Has your child previously been treated by a chiropractor?

- ○ Yes
- ○ No

If yes, when?

____

About Your Child's Health

13. In the past year has your child had any of the following? Please explain in the space provided.

	Yes	No	Please explain
Back or neck pain?			
Pains in legs or arms?			
Headaches?			
Asthma?			
Allergies?			
Earaches?			
Falls from a bicycle, skateboard, scooter, rollerblades or similar?			
Problems with bedwetting?			
Broken bones?			
Any surgeries?			
Is your child presently taking any prescribed medications?			
Do you have any other health concerns about your child’s health?			

About Your Child's Diet

14. What does your child usually eat for breakfast?

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15. What does your child usually eat for lunch?

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16. What does your child usually eat for dinner?

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17. What snacks does your child eat?

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18. What is your child's favorite food?

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19. How much water does your child drink in a day?

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20. Do you have any questions for the doctor?

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