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 _____

CHIROPRACTIC EXAMINATION

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: _____

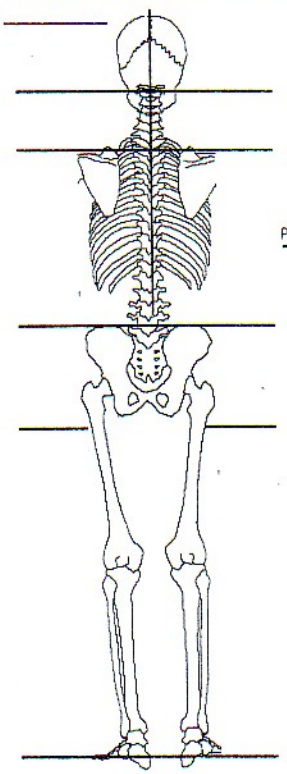
Babinski response (abnormal beyond age 2). Findings:_____

Ortolani's test (hip click). Findings: _____

Grasp reflex (persistence beyond 4 mo. suggests cerebral dysfunction). Findings:_____

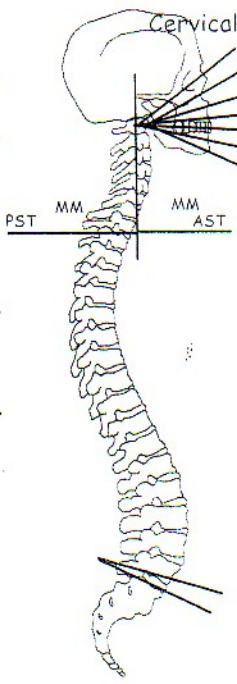
Palpation/Posture Analysis

DATE _____



DATE _____

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 _____

_____

_____

_____