



Beard Chiropractic  
Family Wellness Clinic  
*Better health for you and your family*

## PEDIATRIC NEW PATIENT INFORMATION

### 3 Years to 5 Years

Today's Date: \_\_\_\_\_

**PATIENT INFORMATION:**

Child's Name: \_\_\_\_\_ Child's Nickname: \_\_\_\_\_

Reason for visit: \_\_\_\_\_

Sex: M / F Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Child's SSN: \_\_\_\_\_

Child's Address and Phone (if different from yours): \_\_\_\_\_

Who may we thank for referring you? \_\_\_\_\_

**FAMILY INFORMATION:**

Mother's Name: \_\_\_\_\_ Father's Name: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Home & Work Phone: \_\_\_\_\_ Home & Work Phone \_\_\_\_\_

Parents Marital Status: Married  Single  Divorced  Widowed

List ages of other children in family: \_\_\_\_\_

Predominant language used at home: \_\_\_\_\_

**PAYMENT INFORMATION:**

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

If you have insurance that may cover chiropractic services, 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: \_\_\_\_\_ Birth Date: \_\_\_\_\_ SSN: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Phone No.: \_\_\_\_\_

Employer: \_\_\_\_\_ Group#: \_\_\_\_\_ Insured's ID: \_\_\_\_\_

**CONSENT TO TREAT:**

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 named \_\_\_\_\_ as the examining / treating doctor deems necessary.

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

Parent's Name Printed: \_\_\_\_\_ Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Witnessed by: \_\_\_\_\_

**Please answer the following questions:**

**Yes No**

Does your child complain of pain or discomfort? If yes, when did this occur? \_\_\_\_\_

Was onset sudden  or gradual . Is problem constant  or intermittent .

Has your child ever had this problem before? \_\_\_\_\_

Has your child previously been treated for this problem? By whom? \_\_\_\_\_

Has your child previously had chiropractic care? Previous chiropractor? \_\_\_\_\_

**HEALTH HISTORY:**

**Yes No**

Does your child ever complain of back or neck pain? \_\_\_\_\_

Does your child ever complain of pains in the legs or arms? \_\_\_\_\_

Does your child ever complain of headaches? \_\_\_\_\_

Has your child had asthma? \_\_\_\_\_

Is your child allergic to anything? \_\_\_\_\_

Are there any smokers in the child's home? \_\_\_\_\_

Has your child had any earaches? At what age did the child's first earache occur? \_\_\_\_\_

How frequently does you child have earaches? \_\_\_\_\_

In which ear do your child's earaches usually occur? Right  Left  Both

Is your child presently taking any prescribed medication? \_\_\_\_\_

Please list any other illness which have been a concern for your child: \_\_\_\_\_

Please list any surgeries your child has had : \_\_\_\_\_

Do you have any other concerns about your child's health: \_\_\_\_\_

**TRAUMA:**

**Yes No**

Has your child had any recent falls or trauma: \_\_\_\_\_

Describe the trauma and the date it occurred: \_\_\_\_\_

Has your child ever fallen from a bicycle, skateboard, scooter, rollerblades or similar items? \_\_\_\_\_

Has your child ever fallen down stairs or fallen from a significant height? \_\_\_\_\_

Has your child ever been in a motor vehicle collision or near-miss? \_\_\_\_\_

**Yes No**

- Has your child ever had a bone fracture or joint dislocation? \_\_\_\_\_
- Has your child had any other trauma or injuries? \_\_\_\_\_
- Does your child ever bang his / her head repeatedly against a wall, bed or other object? \_\_\_\_\_

**NUTRITION:**

**Yes No**

- Do you have any concerns about your child's diet? \_\_\_\_\_
- Does your child have any food allergies? \_\_\_\_\_
- Does your child have any persistent or intermittently occurring skin rashes? \_\_\_\_\_
- Does your child take vitamin supplements? \_\_\_\_\_
- Does your child eliminate stools each day? \_\_\_\_\_

For how many months was your child breast-fed? \_\_\_\_\_

What does your child usually eat for Breakfast? \_\_\_\_\_

What does your child usually eat for Lunch? \_\_\_\_\_

What does your child usually eat for Dinner? \_\_\_\_\_

What does your child usually eat for Snacks? \_\_\_\_\_

How much cow's milk does your child drink each day? \_\_\_\_\_

What is your child's favorite food? \_\_\_\_\_

What type of fast foods does your child like to eat? \_\_\_\_\_