



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

PEDIATRIC NEW PATIENT INFORMATION

Birth to 2 Months

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: _____

The following questions are designed to help the doctor provide the best possible spinal care for your child.

How many hours does your baby sleep between feeds? During the day _____ At night _____

Yes No

- Does your baby go to sleep easily? _____
- Does your baby have a preferred sleeping position? _____
- Does your baby cry if you change this sleeping position? _____
- Does your baby have any feeding difficulties? _____
- Is your baby being breast fed? If no, for how long was baby breast fed _____ weeks/months.
- Does your baby have a one sided breast-feeding preference? Left / Right (Please circle one.)
- Is your baby formula fed? Which formula or other milk source? _____
- Does your baby frequently spit-up after feeding? _____
- Does your baby cry a lot? For how many hours each day? _____
- Does your baby pass a lot of intestinal gas? _____
- Does your baby have a preferred head position? _____
- Does your baby frequently arch his/her head and neck backwards? _____
- Does your baby cry or become irritable during a diaper change? _____
- Has baby ever had a fever? _____
- Has your baby had any falls? _____
- Has your baby been in a car accident or near-miss? _____
- Has your baby had any other trauma? _____
- Has your baby been vaccinated? _____
- Do you have any other concerns you wish to discuss? _____

BIRTH HISTORY

LABOR AND DELIVERY:

How long was the labor from the first regular contractions to the birth? _____ hours.

How long was the 2nd stage (the pushing phase) of the labor? _____ hours.

Yes No

- Hospital birth _____
- Home birth _____
- Midwife assisted birth _____

- Vaginal delivery _____
- Planned C-section _____
- Emergency C-section _____

- Was birth induced (pitocin) _____
- Forceps delivery _____
- Vacuum extraction _____

- Anesthesia administered _____
- Fetal distress _____
- Meconium staining _____

- Head presentation _____
- Face presentation _____
- Breech presentation _____

BABY'S CONDITION IMMEDIATELY AFTER BIRTH:

Apgar Scores: At 1 minute ____/10 At 5 minutes ____/10

Baby's Crying Baby cried immediately after birth ____
 Cried strongly ____ Weak Cry ____ Did not cry for ____ minutes

Baby's Color Pink all over ____ Blue face ____ Blue hands / feet ____

Baby's Activity Arms and legs actively moving ____ Floppy baby ____

Intensive Care Was required ____ Number of days in neonatal intensive care unit ____

Medication given a birth? _____ Vaccines administered? _____

Birth Weight _____ lbs/kgs Birth length _____ ins/cms Baby home day _____

PREGNANCY HISTORY

During your pregnancy, did you have any of the following:

	Yes	No
Falls?	<input type="checkbox"/>	<input type="checkbox"/>
Motor vehicle accidents?	<input type="checkbox"/>	<input type="checkbox"/>
Near-miss MVA?	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
Anemia?	<input type="checkbox"/>	<input type="checkbox"/>
Morning sickness?	<input type="checkbox"/>	<input type="checkbox"/>
Indigestion?	<input type="checkbox"/>	<input type="checkbox"/>
Seizures?	<input type="checkbox"/>	<input type="checkbox"/>
Swollen ankles?	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid problems?	<input type="checkbox"/>	<input type="checkbox"/>
Heart problems?	<input type="checkbox"/>	<input type="checkbox"/>
Back pain?	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal bleeding?	<input type="checkbox"/>	<input type="checkbox"/>
Were you hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>
Any other illnesses?	<input type="checkbox"/>	<input type="checkbox"/>

During your pregnancy, did you use any of the following:

	Yes	No
Tobacco?	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol?	<input type="checkbox"/>	<input type="checkbox"/>
Non-prescribed drugs?	<input type="checkbox"/>	<input type="checkbox"/>
Prescription medications?	<input type="checkbox"/>	<input type="checkbox"/> Medications _____ Reason _____
Over-the-counter meds?	<input type="checkbox"/>	<input type="checkbox"/> Medications _____ Reason _____