



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

PEDIATRIC NEW PATIENT INFORMATION

2 Months to 2 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: _____ SS#: _____

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: _____

PREGNANCY HISTORY

What was the term of your pregnancy? _____ weeks

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"/>	_____
Over-the-counter meds	<input type="checkbox"/>	<input type="checkbox"/>	_____

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	<input type="checkbox"/>	<input type="checkbox"/>	_____
Home Birth	<input type="checkbox"/>	<input type="checkbox"/>	_____
Midwife Assisted	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vaginal Delivery	<input type="checkbox"/>	<input type="checkbox"/>	_____
Planned C-Section	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emergency C-Section	<input type="checkbox"/>	<input type="checkbox"/>	_____
Was Birth Induced	<input type="checkbox"/>	<input type="checkbox"/>	_____
Forceps Delivery	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vacuum Extraction	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anesthesia Administered	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fetal Distress	<input type="checkbox"/>	<input type="checkbox"/>	_____
Meconium Staining	<input type="checkbox"/>	<input type="checkbox"/>	_____
Head Presentation	<input type="checkbox"/>	<input type="checkbox"/>	_____
Face Presentation	<input type="checkbox"/>	<input type="checkbox"/>	_____
Breech Presentation	<input type="checkbox"/>	<input type="checkbox"/>	_____

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 Hand / Feet _____

Baby's Activity Arms and Legs Actively Moving _____ Floppy Baby _____

Intensive Care Was Required _____ Days in Neonatal Intensive Care Unit _____

Medication Given at Birth? _____ Vaccines Administered _____

Birth Weight _____ lbs / kgs Birth Length _____ ins / cms Baby Home on Day _____

INFANT HISTORY

The following questions are designed to help the doctor provide a detailed evaluation of your child.

NUTRITION:

Yes No

- Is your child still being breast fed? If no, for how long was he / she breast fed? _____
If still breast feeding, how much cow's milk does the mother consume each day? _____
- Is your child formula fed? Which formula or other milk source? _____
- Is your child eating solid food? What foods does his / her diet contain? _____
What is your child's favorite food? _____
- Does your child have any feeding difficulties? _____
- Does your child have any digestive disturbances? _____
- Does your child have any food allergies? _____
- Does your child have any persistent or intermittent skin rashes? _____
- Is your child receiving any vitamin supplements? _____

TRAUMA:

Yes No

- Has your child had any recent falls or trauma? (What and When) _____
- Has your child ever fallen down stairs or fallen from any height? (Where and When) _____
- Has your child ever been in a motor vehicle collision or near-miss? (What and When) _____
- Has your child ever had a bone fracture or joint dislocation? (Where) _____
- Has your child had any other trauma or injuries? (Describe) _____
- Does your child ever bang his / her head repeatedly against a wall, bed or other object? _____

GROWTH AND DEVELOPMENT:

Yes No

- Can your child sit unsupported? At what age did your child start to sit-up? _____ months
- Is your child crawling yet? At what age did your child start crawling? _____ months
- Is your child walking yet? At what age did your child start walking? _____ months
- Does your child often trip and fall? _____
- Do you have any other concerns about your child's growth and development? _____

HEALTH HISTORY:

Yes No

- Has your child had colic? _____
- Has your child had any upper respiratory infections? How often? _____
- Has your child had asthma? _____
- Does your child ever complain of back or neck pain? _____
- Does your child ever complain of pains in the arms or legs? _____
- Does your child ever complain of headaches? _____
- Has your child had any earaches? At what age did the first earache occur? _____
- How frequently does your child have earaches? _____
- Do your child's earaches usually tend to occur in the same ear? Is it the right or left ear? _____
- Has your child had any other illnesses? Please list each illness and its approximate date _____

Yes No

- Is your child presently receiving any medications? _____
- Has your child ever been to a hospital or emergency room for evaluation or treatment? _____
- Has your child recently been vaccinated? _____
- Do you have any other concerns about your child's health? _____