

Pediatric New Patient Information & Child History Form Pre-School, Age 3-5 years

Today's Date _____

Name _____ Sex _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Child's Nickname _____ Child's SS # _____

Child's home phone # _____

Reason for Today's visit _____

Who may we thank for referring you: _____

Family Information

Mother's name: _____ Father's names: _____

Home phone #: _____ Home phone #: _____

Work phone #: _____ Work phone #: _____

Parent's 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: _____ Date of Birth: _____ SS #: _____

Insurance company name: _____ Phone #: _____

Insurance company address to send claims: _____

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

Parent's name: _____ Signature: _____

Date: _____ Witnessed by: _____

History

Does your child complain of pain or discomfort? _____ If yes, when did this problem first occur? _____

Was onset? Sudden? _____ or Gradual _____ Is problem constant _____ or intermittent _____

_____ Yes _____ No Has your child ever had this problem before?

_____ Yes _____ No Has your child previously been treated for this problem? Dr's. name _____

_____ Yes _____ No Has your child previously been to a chiropractor? _____ When? _____

About your Health—in the past year have you had any of the following:

_____ Yes _____ No Does your child ever complain of back or neck pain? _____

_____ Yes _____ No Does your child ever complain of pains in the legs or arms? _____

_____ Yes _____ No Does your child ever complain of headaches? _____

_____ Yes _____ No Has your child had asthma? _____

_____ Yes _____ No Is your child Allergic to anything? _____

_____ Yes _____ No Has your child had any earaches? _____

At what age did the child's first earache occur? _____

How frequently does your child have earaches? _____

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

_____ Yes _____ No Is your child presently taking any medications? _____

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

_____ Yes _____ No Have you ever had any surgeries? _____

_____ Yes _____ No 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? _____

_____ Yes _____ No Has your child ever fallen from a bicycle, skateboard, scooter, rollerblades or similar? _____

_____ Yes _____ No Has your child ever fallen down stairs or fallen from a significant height? _____

_____ Yes _____ No Has your child ever been in a motor vehicle collision or near miss? _____

_____ Yes _____ No Has your child ever had any broken bones or joint dislocation? _____

_____ Yes _____ No Has your child ever had any other trauma or injuries? _____
_____ Yes _____ No 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? _____
_____ Yes _____ No Does your child have any food allergies? _____
_____ Yes _____ No Does your child have any persistent or intermittently occurring skin rashes? _____
_____ Yes _____ No Does your child take vitamin supplements? _____
_____ Yes _____ No 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 snacks does your child eat? _____

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

What is your child's favorite food? _____

What type of fast food does your child like to eat? _____

Developmental Milestones

Please indicate the most complex skill that your child can perform in each section

In each section, the tasks are arranged in order of increasing developmental age.

Gross Motor Skills

- Able to hold head up from the table momentarily
- Head and shoulder can be supported by the forearms
- Infant can be pulled up into a sitting position by the hands
- Sits unsupported in the upright position
- Head and shoulder can be supported by the arms
- Rolls from prone to supine position
- Crawls
- Stands holding onto furniture
- Walks with someone holding onto one hand
- Walks unassisted
- Runs
- Negotiates stairs placing 2 feet on each step
- Climbs stairs using one foot on each step
- Walks down stairs with one foot on each step
- Hops on one foot

Social Skills

- Smiles
- Reaches for familiar objects
- Plays with hands
- Plays with feet
- Clearly shows joy and pleasure
- Feeds self with fingers
- Plays peek-a-boo
- Understands yes and no

Fine Motor Skills

- Primitive grasp reflex present
- Holds and shakes a rattle placed in the hand
- Grasps objects independently
- Moves an object from one hand to the other
- Self-feeding, can hold and eat a cookie
- Checks objects by placing them in the mouth
- Picks up object with thumb and index finger
- Turns 2 to 3 pages of a book at a time
- Turns pages of a book one at a time
- Builds a tower containing at least 5 blocks
- Builds a tower containing at least 10 blocks

Communication skills

- Makes cooing sounds
- Laughs
- Uses one syllable words such as "da"
- Uses 2 syllable words such as "dada"
- Uses 2 to 3 word vocabulary
- Uses 2 to 3 word phrases

Adaptive skills

- Feeds from a cup unassisted
- Holds own bottle
- Feeds self with utensils
- Able to identify and match some colors
- Copies a circle
- Copies a cross