

**Pediatric New Patient Information & Child History Form School - Age, 6 years and older**

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

When did this problem first occur? \_\_\_\_\_

\_\_\_\_\_ Yes \_\_\_\_\_ No Have you ever had this problem before?

\_\_\_\_\_ Yes \_\_\_\_\_ No Have you previously been treated for this problem? Dr's. name \_\_\_\_\_

\_\_\_\_\_ Yes \_\_\_\_\_ No Have you previously been to a chiropractor? \_\_\_\_\_ When? \_\_\_\_\_

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

\_\_\_\_\_ Yes \_\_\_\_\_ No Back or neck pain? \_\_\_\_\_

\_\_\_\_\_ Yes \_\_\_\_\_ No Pains in the legs or arms? \_\_\_\_\_

\_\_\_\_\_ Yes \_\_\_\_\_ No Headaches? \_\_\_\_\_

\_\_\_\_\_ Yes \_\_\_\_\_ No Asthma? \_\_\_\_\_

\_\_\_\_\_ Yes \_\_\_\_\_ No Allergies? \_\_\_\_\_

\_\_\_\_\_ Yes \_\_\_\_\_ No Earaches? \_\_\_\_\_

\_\_\_\_\_ Yes \_\_\_\_\_ No Falls from a bicycle, skateboard, scooter, rollerblades or similar? \_\_\_\_\_

\_\_\_\_\_ Yes \_\_\_\_\_ No Do you ever have a problem with bedwetting? \_\_\_\_\_

\_\_\_\_\_ Yes \_\_\_\_\_ No Have you ever been in a motor vehicle accident? \_\_\_\_\_

\_\_\_\_\_ Yes \_\_\_\_\_ No Have you ever had any broken bones? \_\_\_\_\_

\_\_\_\_\_ Yes \_\_\_\_\_ No Have you ever had any surgeries? \_\_\_\_\_

\_\_\_\_\_ Yes \_\_\_\_\_ No Are you at present taking any medications? \_\_\_\_\_

\_\_\_\_\_ Yes \_\_\_\_\_ No Do you have any other health problems? \_\_\_\_\_

### About your lifestyle

What grade are you in school? \_\_\_\_\_

How do you carry your school bag? \_\_\_\_\_

How heavy is your school bag? \_\_\_\_\_

What sports do you play? \_\_\_\_\_

What hobbies do you have? \_\_\_\_\_

How many hours each day do you watch TV? \_\_\_\_\_

How many hours each day do you spend using a computer? \_\_\_\_\_

How often do you play video games? \_\_\_\_\_

On average, how many hours sleep do you get each night? \_\_\_\_\_

Are there any smokers in your family? \_\_\_\_\_

Do you feel stressed out? \_\_\_\_\_  
Do you have trouble reading the board in class? \_\_\_\_\_  
Do you ever have blurred vision? \_\_\_\_\_  
Do you wear glasses or contact lenses? \_\_\_\_\_  
Do you sometimes get headaches when you read? \_\_\_\_\_

**About your diet**

What do you usually eat for breakfast? \_\_\_\_\_  
\_\_\_\_\_  
What do you usually eat for lunch? \_\_\_\_\_  
\_\_\_\_\_  
What do you usually eat for dinner? \_\_\_\_\_  
\_\_\_\_\_  
What snacks do you eat after school? \_\_\_\_\_  
What is your favorite food? \_\_\_\_\_  
How much water do you drink each day? \_\_\_\_\_  
How many sodas or colas do you drink each day? \_\_\_\_\_  
How often do you eat fast food items? \_\_\_\_\_