Pediatric New Patient Information & Child History Form Newborn, Birth to 2 months

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:______________________

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History

How many hours does your baby sleep between feeds? during day__________ during night__________

_____Yes_____No Does your baby go to sleep easily?__________

_____Yes_____No Does your baby have a preferred sleeping position?__________

_____Yes_____No Does baby cry if you change the sleeping position?__________

_____Yes_____No Does baby have any feeding difficulties?__________

_____Yes_____No Is baby breast-fed? If no, for how long was baby breast feed _____ weeks/months

_____Yes_____No Does baby have a one sided breast feeding preference? Preferred breast left / right

_____Yes_____No Is baby formula fed? Which formula or other milk source?__________

_____Yes_____No Does baby frequently spit-up after feeding?__________

_____Yes_____No Does your baby cry a lot? For how many hours each day?__________

_____Yes_____No Does baby pass a lot of intestinal gas?__________

_____Yes_____No Does baby have a preferred head position?__________

_____Yes_____No Does baby frequently arch his/her head and neck backwards?__________

_____Yes_____No Does baby cry or become irritable during a diaper change?__________

_____Yes_____No Has baby ever had a fever?__________

_____Yes_____No Has baby had any falls?__________

_____Yes_____No Has baby been in a car accident or near-miss?__________

_____Yes_____No Has baby had any other trauma?__________

_____Yes_____No Has your baby been vaccinated?__________

_____Yes_____No Do you have any other concerns?__________

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Pregnancy history

Mother's name:______________________ How many children do you have?______________

What was the term of your pregnancy?______________________________weeks

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

Falls? ________Yes________No ______________________________

Motor vehicle accidents? ________Yes________No ______________________________

Near-miss mva? ________Yes________No ______________________________

High B.P.? ________Yes________No ______________________________

Diabetes? ________Yes________No ______________________________

Anemia? ________Yes________No ______________________________

Morning sickness? ________Yes________No ______________________________

Indigestion? ________Yes________No ______________________________

Seizures? ________Yes________No ______________________________

Swollen ankles? ________Yes________No ______________________________

Thyroid problems? ________Yes________No ______________________________

Heart problems? ________Yes________No ______________________________

Back pain? ________Yes________No ______________________________

Abnormal bleeding? ________Yes________No ______________________________

Were you hospitalized? ________Yes________No ______________________________

Any other illnesses? ________Yes________No ______________________________

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

Tobacco? ________Yes________No ______________________________

Alcohol? ________Yes________No ______________________________

Non-prescribed drugs? ________Yes________No ______________________________

Prescription medications? ________Yes________No ______________________________

Over-the-counter meds? ________Yes________No ______________________________

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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 labor? ____________________ hours

Hospital birth	______Yes	______No	____________________
Home birth	______Yes	______No	____________________
Midwife assisted	______Yes	______No	____________________
Vaginal delivery	______Yes	______No	____________________
Planned c-section	______Yes	______No	____________________
Emergency c-section	______Yes	______No	____________________
Was birth induced (pitocin)	______Yes	______No	____________________
Forceps delivery	______Yes	______No	____________________
Vacuum extraction	______Yes	______No	____________________
Anesthesia administered	______Yes	______No	____________________
Fetal distress	______Yes	______No	____________________
Meconium staining	______Yes	______No	____________________
Head presentation	______Yes	______No	____________________
Face presentation	______Yes	______No	____________________
Breech presentation	______Yes	______No	____________________

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 strong ______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 ______ days in neonatal intensive care unit

Medication given at birth? ____________________ Vaccines administered ____________________

Birth weight __________ lbs / kgs, Birth length ________ ins / cms, Baby home on day______________

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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

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