



New Patient
Child

Full Name: _____ Today's Date: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone Numbers: (Home) _____ (Work) _____ (Cell) _____
Social Security Number: _____ Birthdate: _____ Age: _____
Emergency Contact Name: _____ Phone Number: _____
Relationship: _____
Parent/Guardian Full Name: _____

Financial Responsibility

Check one payment type: Cash Check Credit Card Care Credit
Does the child have insurance? No Yes
Does the child have Medicaid? No Yes
Insurance Company: _____ Policy Holder's Date of Birth: _____
Your Relationship to Policy Holder: _____ Policy Holder's SS# _____

Reason For This Visit

Describe the reason for this visit: _____
Is the purpose of this visit related to Sports Auto Fall Home Injury Other
Please Explain: _____
When did this condition begin? _____
Has this condition: Worsend Stayed Constant Improved
Does this condition interfere with: Sleep Daily Routine Other Activities
Please Explain: _____
Has this child seen any other doctors for this condition? Yes No
Doctor's Names: _____
Type of Treatment: _____ Results: _____
How were you referred to our clinic? _____

Vaccinations

Is your child vaccinated? Yes No
If yes, check all that your child has received:
 DPT MMR Chicken Pox Hepatitis Other
Describe any and all reactions to vaccine(s): _____

Mother's Pregnancy & Labor



During Pregnancy: Drugs/Medicine Tobacco/Alcohol

Please Explain: _____

Illness During Pregnancy? _____

How was your delivery? Labor Chemically Induced Labor was doctor assisted
 Premature delivery Doctor pulled or twisted on baby
 Vacuum/Forceps Extraction C-section

Did you nurse your baby? Yes No

Did your baby have colic? Yes No

Feeding problems? Yes No

Child's Health History

Please check each of the disease or conditions that your child has now or has had in the past.

- Allergies Breathing Problems Frequent Colds Skin Problems
- Colic Headaches Sleeping Problems Attention Problems
- Hyperactivity Tubes in Ears Back Pain Digestive Problems
- Vision Problems Bed Wetting Ear Problems Neck Pain
- Asthma Constipation Irritability Other

Child's Current Health Status

Has your child ever:	No	Yes	<u>If Yes, please explain</u>
Taken antibiotics?	<input type="radio"/>	<input type="radio"/>	_____
Been hospitalized?	<input type="radio"/>	<input type="radio"/>	_____
Been in a car accident?	<input type="radio"/>	<input type="radio"/>	_____
Is your child accident prone?	<input type="radio"/>	<input type="radio"/>	_____
Had surgery?	<input type="radio"/>	<input type="radio"/>	_____
Had a sports related injury?	<input type="radio"/>	<input type="radio"/>	_____
Currently taking medications?	<input type="radio"/>	<input type="radio"/>	_____
Having difficulty interacting with others?	<input type="radio"/>	<input type="radio"/>	_____

Have you or our anyone else noticed that your child is nervous, twitches, shakes, or exhibits rocking behavior? Yes No

What changes (if any) in your child's health or behavior would you like to accomplish?

Authorization For Care Of A Minor

I hereby authorize the doctor in this healthcare facility and whomever they may designate as their assistant to administer treatment to work with my child's condition through the use of adjustments and procedures the doctor deems appropriate. I clearly understand and agree that all services rendered to my child are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at the facility. The doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand if I suspend or terminate my child's care for any reason, any fees for professional services rendered to my child will become immediately due and payable.

Name of Parent/Guardian: _____

Signature of Parent/Guardian: _____

