MOVE MOUNTAINS
CHIROPRACTIC

Pediatric New Patient

Child's name:_____ **DOB:**_____
Address:_____
Phone:_____
Mother's name:_____ **Mother's Mobile:**_____
Father's name:_____ **Father's Mobile:**_____
Pediatrician/Family MD:_____ **Last Visit:**_____

Birth Weight:_____ **Birth Height:**_____ **Current Weight:**_____ **Current Height:**_____

Purpose of this visit: Wellness Check-up Injury/Accident Other:_____
If your child is experiencing pain/discomfort please identify where_____
When did the problem first begin? Date:_____ Unknown Gradual Sudden
Ever had this problem before? No Yes If yes, when?_____
Any bowel/bladder problems since this problem began? No Yes
If yes, describe:_____
Have you seen any other doctors for this problem? No Yes If yes, who?_____
How long ago?_____ What were the results of past treatment?_____
How is this problem now: Rapidly Improving Improving Slowly About the same
Gradually Worsening On & Off
Please list any medications:_____
Has your child ever sustained an injury playing organized sports? No Yes
If yes, explain:_____
Has your child ever sustained an injury in an auto accident? No Yes
If yes, explain:_____

Has your child ever suffered from: (circle)

Headaches	Orthopedic problems	Digestive disorders	Behavioral Problems
Dizziness	Neck problems	Poor appetite	ADD/ADHD
Fainting	Arm problems	Stomach Ache	Ruptures/Hernia
Seizures/Convulsions	Leg problems	Reflux	Muscle Pain
Heart Trouble	Joint problems	Constipation	Growing Pains
Chronic Earaches	Backaches	Diarrhea	Allergies to _____
Sinus Trouble	Poor posture	Hypertension	Asthma
Scoliosis	Anemia	Colds/Flu	Walking Trouble
Bed Wetting	Colic	Broken Bones	Sleeping problems
Fall in baby walker	Fall from bed/couch	Fall from crib	Fall off swing
Fall off bicycle	Fall from high chair	Fall off slide	Fall down stairs
Fall from changing table	Fall off monkey bars	Fall off skateboard/skates	Other:_____

I understand that I am directly and fully responsible to Move Mountains Chiropractic for all fees associated with chiropractic care my child receives.

The risks associated with exposure to ionization and spinal adjustments have been explained to me to my complete satisfaction, and I have conveyed my understanding of these risks to the doctor. After careful consideration I do hereby request and authorize imaging studies and chiropractic adjustments for the benefit of my minor child for whom I have the legal right to select and authorize health care services on behalf of.

___ Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other guardian is not required. If my authority to so select and authorize this care should change in any way, I will immediately notify this office.

_____ _____

Parent or Legal Guardian's Signature Date

_____ _____

Doctor Signature Date