MOVE MOUNTAINS
CHIROPRACTIC

Pediatric New Patient

Child's name:_____ **DOB:**_____
Address:_____
Phone:_____
Mother's name:_____ **Father's name:**_____
Email:_____
How did you hear about us?:_____
Pediatrician/Family MD:_____
Is your child receiving care from any other professionals? If yes, list specialty:
_____
Please list any drugs/medications/vitamins that your child is taking: _____
Birth Weight:_____ **Birth Height:**_____

What health condition(s) bring your child to be evaluated by a chiropractor?
_____
When did the condition first begin? _____
How did the problem start? Suddenly Gradually Post-Injury
Has you child ever received care for this condition before? Yes No
If yes, please explain: _____
Is this condition: Getting worse Improving Intermittent Constant Unsure
What makes the problem better? _____
What makes the problem worse? _____

What are your top three health goals for your child:
1._____
2._____
3._____
What would you like to gain from chiropractic care? Resolve existing condition Overall wellness Both
Have you ever visited a chiropractor? Yes No
What is their specialty? Pain relief Physical therapy & rehab Nutritional Subluxation-based Other

Please tell us about your pregnancy
- Any fertility issues? Yes No **If yes, please explain:** _____
- Did mother smoke? Yes No **If yes, how many per week?** _____
- Did mother drink? Yes No **If yes, how many per week?** _____
- Did mother exercise? Yes No **If yes, please explain:** _____
- Was mother ill? Yes No **If yes, please explain:** _____
- Any ultrasounds? Yes No **If yes, please explain:** _____

Please explain any notable episodes of mental or physical stress during your pregnancy: _____
_____

Please explain any other concerns or notable remarks about your child's conception or pregnancy:
_____

Labor and Delivery History

- Child's birth was: Natural vaginal birth Scheduled C-section Emergency C-section

- Child's birth was: At home At a birthing center At a hospital Other

- At how many week's was your child born? _____

Please circle any applicable interventions or complications:

Breech Induction Pain meds Epidural Episiotomy Vacuum extraction Forceps Other _____

Please describe any other concerns or notable remarks about your child's labor and/or delivery.

_____

Growth and Development History

Is/was your child breastfed? Yes No **If yes, how long? _____ Difficulty with breastfeeding?** Yes No

Did they ever use formula? Yes No **If yes, at what age?_____ If yes, what type? _____**

Did/does your child ever suffer from colic, reflux, or constipation as an infant? Yes No

If yes, please explain: _____

Did/does your child frequently arch their neck/back, feel stiff, or band their head? Yes No

If yes, please explain: _____

At what age did the child: Respond to sound _____ Follow an object _____ Hold their head up_____

Vocalize _____ Teethe_____ Sit alone _____ Crawl _____ Walk _____

Begin cow's milk _____ Begin solid foods_____

Please list any food intolerance or allergies, and when they began: _____

_____

Please list your child's hospitalization and surgical history, including the year: _____

_____

Please list any major injuries, accidents, falls and/or fractures your child has sustained in his/her lifetime, including the year: _____

_____

Have you chosen to vaccinate your child? No Yes, on delayed schedule Yes, on schedule

If yes, please list any vaccination reactions: _____

Has you child received any antibiotics? Yes No

If yes, how many times and list reason: _____

Night terrors or difficulty sleeping? Yes No **If yes, please explain: _____**

Behavioral, social or emotional issues? Yes No **If yes, please explain: _____**

How many hours per day does your child typically spend watching a TV, computer, tablet or phone?

_____

How would you describe your child's diet?

Mostly whole, organic foods Pretty average High amount of processed foods

Acknowledgement and Consent

_____ _____

Parent or Legal Guardian's Signature Date

_____ _____

Doctor Signature Date