PEDIATRIC NEW PATIENT
INTAKE • HEALTH PROFILE • HISTORY

Date ___/___/___

PEDIATRIC PATIENT INFORMATION

Print Full Name____ Today's Date ________________

Street Address_____________________________ City _____________________ State_____ Zip ________

Age _____ Date of Birth __________________Height ________Weight ________

Names of Parents/Guardian: ________________________ Ages of Siblings____________________________

Home phone (_____) _____________ Cell Phone (_____) _____________ Business Phone (____) ______________

E-mail address ____________________________________ Best Way to Contact you ____________________

Emergency contact (name-Relationship) ______________ (Where they could be reached) ________________________

Whom may we thank for referring you to our office? ____

Insurance Co. ________________ Policy #__________________ Policy Holder________________________

REASON FOR SEEKING CHIROPRACTIC CARE

Purpose of today's office visit? ____

Other doctors seen for this Condition: YES / NO. Doctors' Names and Prior Treatments: ____________________________

____

Other Health Problems? ____

Check any of the following conditions your child has suffered from during the past six months:

- ☐ Ear Infections
- ☐ Asthma/Allergies
- ☐ Colic
- ☐ Scoliosis
- ☐ Digestive Problems
- ☐ Bed Wetting
- ☐ Seizures
- ☐ ADHD
- ☐ Car Accident
- ☐ Chronic Colds
- ☐ Recurring Fevers
- ☐ Headaches
- ☐ Growing Pains
- ☐ Temper tantrums / Mood altered
- ☐ Difficulty Sleeping
- ☐ Other ___________________________

Family History ____

Previous Chiropractic Care YES / NO Last Visit:__________ Name of Dr. ___________________________________

Name of Pediatrician: ____

Date of Last Visit: ________________ Reason & treatment/prescriptions:_____________________________________

# of Prescriptions that your child has taken: During the past 6 mo ____ Total During his/her lifetime ____ List _________________

PRENATAL HISTORY

Name of Obstetrician or Midwife: ____

Location of Birth _________________________ Circle One: Hospital / Birthing Center / Home

How was the birth? _________________________________ Any Complications? ____________________________

Check all that apply ___ Vaginal ___ C-section ___ Emergency ___ Planned ___ Forceps used ___Vacuum Extraction ___ Induced

Any Meds During Pregnancy / Delivery? YES /NO List ______________ Birth Weight & Length ________________________

FEEDING HISTORY

Breast Fed YES / NO? How Long ______ Formula Fed YES / NO? How Long ______ Intro to Solids: ______ Months

Food / Juice Allergies Intolerances: YES / NO , List ______________________________

TRAUMA HISTORY

Is / has your child been involved in any high impact or contact type sports (i.e. Soccer, Football, Gymnastics, Lacrosse,

Cheerleading,

Martial Arts, Etc)? YES / NO, List ______________________________

Has your child ever been involved in a car accident? YES / NO , List ______________________________

Has your child ever been seen on a Emergency Basis YES / NO , List ______________________________

Prior Surgery: YES / NO, List ______________________________

Childhood Diseases:

Chicken Pox Yes / No Age ____ Measles Yes / No Age ____ Mumps Yes / No Age ____ Rubella Yes / No Age ____

Whooping Cough Yes / No Age ____ Other Yes / No Age ____ Describe ______________________________

CONSENT TO EVALUATE AND TREAT A MINOR

I certify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to Danvers Family Chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

I, ______________________ being the parent or legal guardian of ______________________, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care at Danvers Family Chiropractic.

______________________________ ______________________

LEGAL GUARDIAN SIGNATURE DATE