OFFICE USE ONLY:
GI MC PI Cash
Doctor: ______________________
Insurance: ______________________

NEW PATIENT INFORMATION: PEDIATRIC

Last Name: ______________________________ First Name: __________________________ Middle Initial: __________

Parent/Guardian Last Name: ___________________________________ First Name: ______________________________

Date of Birth: _____/_____/_____ Age: _______ Gender (circle one): Male Female SSN: _____-____ -_____

Height: __________ Weight: __________ Has patient previously received Chiropractic care? Yes No X-rays taken? Yes No

Pediatrician Name: ____

Address: ____

City: ___________________________________ State: __________________________ Zip: ___________________

Home#: ____Cell#: ____

Email: ____

Would you like to receive appointment confirmations? (check one) ☐text -cell phone provider: _____________ ☐email

How did you hear about us?
Patient: ________________________ Doctor: __________________________ Staff Member: ____________________
☐ Drove-by/Walk-in ☐ Insurance ☐ Internet ☐ Advertisement:__________________ ☐ Other: ____________________

Please list medications and/or supplements patient is currently taking:

Medication/Supplement	Dosage/Frequency	Medication/Supplement	Dosage/Frequency

Is patient allergic to any foods and/or medications? ____
____
____

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Patient Name:_______________________________________ Date of Birth:________________________

PRESENT CONDITION ASSESSMENT

List conditions in order of concern:	Pain Scale:	Date of Onset:
1.	*minor* 1 2 3 4 5 6 7 8 9 10 *extreme*	
2.	*minor* 1 2 3 4 5 6 7 8 9 10 *extreme*	
3.	*minor* 1 2 3 4 5 6 7 8 9 10 *extreme*	
4.	*minor* 1 2 3 4 5 6 7 8 9 10 *extreme*	
5.	*minor* 1 2 3 4 5 6 7 8 9 10 *extreme*	

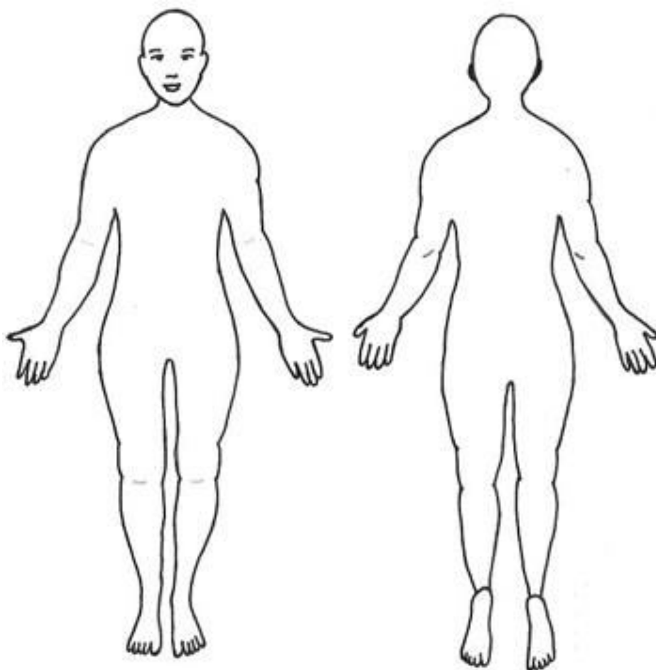
Are any of these condition(s) related to:
□ sports injury
□ auto accident
□ job related
□ other

Has the condition changed since onset? □ Yes □ No □ Better □ Worse

What makes the pain better? ____

What makes the pain worse? ____

Who have you seen for this condition?
□ Chiropractor
□ Medical Doctor
□ Physical Therapist
□ Other



Please indicate on the figures where patient has any of the following:
A = Ache
SF = Stiffness
SH = Sharp
S = Soreness
N = Numbness
P = Pain
C = Constant
XX = Other

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Patient Name:____ **Date of Birth:**___________________________

HEALTH HABITS AND ACTIVITIES

Please select activities patient participates in:

□ Soccer □ Football □ Gymnastics □ Karate □ Hockey □ Basketball □ Lacrosse □ Dance □ Wrestling □ Rugby □ Hockey □ Baseball/Softball □ Volleyball □ Tennis □ Swimming □ Other	□ TV Watching how long per day? _____________ □ Playing Video Games, how long per day?________ □ Computer time, how long per day? ____________ Does patient slouch when sitting? Yes No Does patient slouch when standing? Yes No Patient's Diet: □ well-balanced □ average □ high sugar/processed foods Does patient consume artificial sweeteners? Yes No Water: _________ cups/per day □tap □ bottled □ other Other drinks patient consumes: _____________________________ Servings of fruit: ____________ per day Vegetables: _____________per day Primary/Preferred Sleep Position: □back □side □stomach Quality of sleep: □good □fair □poor

MEDICAL HISTORY

Is patient adopted? Yes No

Prenatal:

Any complications during pregnancy? Yes No **Please Explain:** ____

Did the mother smoke? Yes No **Consume alcohol?** Yes No **Medications taken during pregnancy:** __________________________

Did mother receive ultrasounds? Yes No **Frequency:** ____

Labor/Delivery History:

Place of birth: □ Hospital □ Home □ Birthing Center **Provider:** □ OB-Gyn □ Midwife □ Other

Delivery Method: □ Vaginal □ C-Section

Was labor induced? Yes No Please explain: ____

Delivery position: □ Back □ Squatting □ Other:____

Use of pain medications: Yes No **Please list:** ____

Please select if any of the following occurred: □Twisting/ Pulling during birth □ Vacuum Extraction □ Forceps used □ Other

Newborns

APGAR score: ______/10 5-10 minutes ______/10 □Unsure **Did patient have a misshaped skull/head?** Yes No

Were there purple markings on patients face? Yes No

Post-Delivery History:

Breastfed: Yes No Until what age?: _____________________**Was one breast preferred over the other? If so**, □ Left □ Right

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Patient Name:_______________________________________ Date of Birth:________________________

Food allergies, please list: ____

Supplements taken, please list: ____

Antibiotics, please list: ____

Surgeries: ____

Is patient immunized? Yes No
Reason for vaccination(s): □ Informed decision □ Recommended □ I didn't know there was a choice
Did patient suffer from any negative reactions? Yes No **Please explain:** ______________________________________

Please select all that apply:

	Age		Age		Age
□ Fell out of crib/bed		□ Sleeping problems		□ Scoliosis	
□ Fell from changing table		□ Fell down stairs		□ Learning difficulties	
□ Fell from tree		□ Frequent Fevers		□ Bed wetting	
□ Frequent ear infections		□ Frequent infections/colds		□ Sports accident	
□ Constipation		□ Colic		□ Asthma	
□ Auto Accident		□ Tonsillitis		□ Allergies	
□ Frequent Crying Spells		□ Weight gain/loss		□ Leg/Knee Pain	
□ Fell from playground equipment		□ Stomach Pains		□ Autism	
□Frequent Diarrhea		□ Hyperactivity			

CONSENT TO TREAT A MINOR

I hereby request and consent to the performances of chiropractic adjustments and other chiropractic procedures. This includes various modes of physical therapy and diagnostic x-rays on the named patient, for whom I am legally responsible, by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the Healing Arts Center of Lenexa. I have had an opportunity to discuss the nature and purpose of chiropractic adjustments and other procedures with the doctor of chiropractic named below and/or with other clinic personnel. I understand that results are not guaranteed. I understand that in the practice of chiropractic, as in the presence of medicine, there are some risks. I do not expect the doctor to be able to anticipate and explain all risk and complications. I wish to rely upon the doctor to exercise judgement during the course of the procedure, which the doctor feels at the time is in the patient's best interest, based upon the facts then known to him or her. I have also had the opportunity to ask questions about is content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for the present condition and for any future condition(s) for which I seek treatment.

______________________________ ______/_______/_______
Patient Name Date of Birth

______________________________ ________________________
Parent/Guardian Signature Date

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