shift chiropractic

PEDIATRIC NEW PRACTICE MEMBER APPLICATION

PATIENT INFORMATION

Child's Name_____Parent(s)/Guardian(s) Name_____

Address_____ City_____

State_____ Zip_____

Home Phone _____ Cell Phone _____ E-mail _____

Child's Birthdate _____ Age _____

Has your child ever received chiropractic care? YES NO

If yes, please tell us the doctor's name and date of last appointment _____

Were you pleased with your care? YES NO

How did you find out about our office? _____

Is this appointment related to an auto accident? YES NO

Is your child receiving care from other health professionals? YES NO

If yes, please name them and their specialty _____

Who is your family's primary care physician _____

Please list any drugs or medications your child is taking _____

_____

Please list any vitamins/herbs/homeopathics/other your child is taking _____

_____

Please list any allergies your child has _____

CURRENT HEALTH

What health condition(s) brings your child to our office? _____

_____

When did the symptoms first begin? _____

How did the problem start? SUDDENLY GRADUALLY POST-INJURY

Is this condition: GETTING WORSE IMPROVING INTERMITTENT CONSTANT

What makes the problem better? _____

What makes the problem worse? _____

Has your child ever had a similar condition? YES NO

If yes, please explain _____

Has your child been treated for this problem before? YES NO

If yes, please explain _____ Does your child have regular bowel/bladder movements? YES NO

Has your child ever been checked for vertebral subluxations? YES NO DON'T KNOW

HEALTH HISTORY

Child's birth was: AT HOME AT A BIRTHING CENTER AT A HOSPITAL

My obstetrician/midwife/family physician was_____

Child's birth was (circle all that apply):

NATURAL VAGINAL	VAGINAL WITH INTERVENTIONS	INDUCTION
EPIDURAL	VACUUM EXTRACTION	EPISIOTOMY
FORCEPS	C-SECTION	OTHER
PAIN MEDICATION		

Please list reasons for any interventions/complications _____

_____

Child's birth weight _____ Current weight _____ Current height _____

GROWTH AND DEVELOPMENT

Was your child alert and responsive within 12 hours of delivery? YES NO

If no, please explain _____

At what age did your child: Hold head up _____ Vocalize _____ Sit alone _____

Crawl _____ Walk _____

Patient Hospitialization/Surgical history (please list below all surgeries and hospitalizations, including the year): _____

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

_____

Please list any foods/juice intolerance_____

Did mother smoke during pregnancy? YES NO Did mother drink alcohol during pregnancy? YES NO

Any illness of mother during pregnancy? YES NO

If yes, please explain including treatment/medications/supplements_____

_____

_____

List any drugs/medications (including over the counter) taken during pregnancy_____

_____

Any smokers at home? YES NO Has child received any vaccinations? YES NO

If yes, which ones and list any reactions_____

_____Has

child received any antibiotics? YES NO

If yes, how many times and list reason_____

Any difficulty with breastfeeding? YES NO If yes, please explain_____

_____

Any behavioral problems? YES NO If yes, please explain_____

_____

Any night terrors, sleepwalking or difficulty sleeping? YES NO If yes, please explain_____

_____Does

your child seem normal for their age? YES NO If no, please explain_____

_____

FAMILY HISTORY REVIEW

Check those involving immediate family and add identification: M=Mother; F=Father; S=Siblings; G=Grandparents

▢ Cancer, type_____ ▢ M ▢ F ▢ S ▢ G	▢ Depression ▢ M ▢ F ▢ S ▢ G	▢ Diabetes ▢ M ▢ F ▢ S ▢ G	▢ Back Problems ▢ M ▢ F ▢ S ▢ G ▢
▢ Heart Disease ▢ M ▢ F ▢ S ▢ G	▢ Liver Disease ▢ M ▢ F ▢ S ▢ G	▢ High Blood Pressure ▢ M ▢ F ▢ S ▢ G	▢ Lung Problems ▢ M ▢ F ▢ S ▢ G ▢
▢ Scoliosis ▢ M ▢ F ▢ S ▢ G	▢ Neck Problems ▢ M ▢ F ▢ S ▢ G	▢ Osteoporosis ▢ M ▢ F ▢ S ▢ G	▢ Seizures ▢ M ▢ F ▢ S ▢ G ▢
▢ Osteoarthritis ▢ M ▢ F ▢ S ▢ G	▢ Rheumatoid Arthritis ▢ M ▢ F ▢ S ▢ G	▢ Headaches/Migraines ▢ M ▢ F ▢ S ▢ G	▢ Autism ▢ M ▢ F ▢ S ▢ G ▢

Do any of your friends or relatives see a chiropractor? YES NO

If yes, do they use chiropractic for: HEALTH OPTIMIZATION HEALTH PROBLEMS BOTH

Is your child seeking chiropractic for: HEALTH OPTIMIZATION HEALTH PROBLEMS BOTH

What would you like your child to gain from chiropractic care?_____

_____

_____