New Beginnings Chiropractic Pediatric Patient Health Intake and Questionnaire

CONFIDENTIAL PATIENT INFORMATION

Child's Name: **Parent/Guardian:** **Date:**

SSN#: **DOB:** **Age:** **Male** **Female**

Any other children in family? ( ) Yes ( ) No **If yes, ages:**

Street Address: **Height:**

City, State, Zip: **Weight:**

Email: **Cell Phone:** **Other Phone:**

Emergency Contact: **Relationship:** **Emergency Phone:**

How did you hear about us? (Facebook, Google, Friend, etc)

Who is you r primary care doctor?

Date and reason for your last doctor visit?

Is your child receiving care from any other health professional(s)? If yes, please name them and their specialty.

Please note any significant family medical history:

Please list any drugs/medications/herbs/vitamins/other your child is taking and why:

CURRENT HEALTH CONDITIONS

What health condition(s) bring your child in to be evaluated by a chiropractor?

When did this first begin? **How did it start? ( ) Suddenly ( ) Gradually ( ) Post-injury**

Has your 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 it better? **What makes it worse?**

HEALTH GOALS FOR YOUR CHILD: Top 3 Goals

1. _____
2. _____
3. _____

What would you like to gain from chiropractic?

( ) Resolve existing condition

( ) Overall wellness

( ) Both

PREGNANCY AND FERTILITY HISTORY

Any fertility issues? ( ) Yes ( ) No If yes, please explain:

Did mother smoke? ( ) Yes ( ) No **Did mother drink? ( ) Yes ( ) No** **Any ultrasounds? ( ) Yes ( ) No**

Did mother exercise? ( ) Yes ( ) No **Was mother ill? ( ) Yes ( ) No** **Stressful pregnancy? ( ) Yes ( ) No**

Please explain any notable concerns about conception, pregnancy or stress: