Pediatric New Patient Paperwork

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PATIENT INFORMATION

Child's Name:_____ Date:_____
Parent/Guardian Name:_____
Address:_____ City_____
State_____ Zip: _____ Gender: ☐Male ☐Female
D.O.B:_____/_____/_____ Age_____ Height:_____ Weight:_____
Other Children's names/ages:

_____
Parents Email: _____
Home Phone: _____Cell Phone_____
How did you hear about us?

_____
Has your child been adjusted by a chiropractor before? ☐YES ☐NO
If yes, reason for those visits: _____
When was the last visit?_____
Is your child currently receiving care from other health professionals? ☐YES ☐NO If yes, list name and specialty: _____
Who is your families primary care physician?_____
Contact info for primary care physician _____

HEALTH HISTORY
Describe the health concern that prompted this visit:_____
When did this concern begin? _____
How did this concern begin? _____
Has this condition: ☐Worsened ☐Stayed the same ☐Been Intermittent
Does this interfere with: ☐School ☐Sleep ☐Daily Routine What makes this condition worse?

_____
What makes this condition better? _____
Has your child seen anyone else for this concern? ☐YES ☐NO
Type of treatment:_____
Please list any medications your child is currently taking + dosage (including OTC):_____

_____

_____

BIRTH INFORMATION

Child's birth was at: ☐Home ☐Birthing Center ☐Hospital OB/Midwife/Physician was:_____

Child's birth was: ☐Natural vaginal with no medications ☐Vaginal with interventions: ☐Pitocin ☐ Epidural ☐Pain Medications ☐Vacuum Extraction ☐Forceps ☐IV antibiotics ☐Other:_____ ☐C-Section: ☐Scheduled ☐Emergency ☐Adopted ☐Prenatal history unknown ☐Birth history unknown

Was your child at anytime during your pregnancy in a constrained position?: ☐ YES ☐NO ☐ UNSURE If yes, please describe: ☐Breech ☐Transverse ☐Face/Brow presentation

Complications during pregnancy: ☐ YES ☐NO

(If yes, describe)_____

_____

Medications during pregnancy: : ☐YES ☐NO

If so, which ones and how often? (include OTC): _____

Exposure to drugs, alcohol, cigarettes, or second hand smoke during pregnancy: ☐YES ☐NO

(If yes, describe)_____

Birth Weight:_____lbs _____oz Birth Height:_____

TRAUMAS/INJURY Please list all hospitalizations and surgical history (include year):_____

_____

_____

Please list any major injuries, accidents, falls and/or fractures you child has sustained in his/her lifetime:

_____

_____

_____

The human body is designed to be healthy! The primary system in the body, which coordinates health and function, is the nervous system. Your nervous system is surrounded and protected by the bones of the spine, called vertebrae. Many of the common health challenges that adults experience have their origins during the developmental years, starting at birth. Layers of damage to the spine and nervous system occur as a result of various traumas, toxins, and emotional stress. The result may be misalignment to the spinal column and damage to the nervous system – a condition called Vertebral Subluxation. Please answer the following questions to give us a better understanding about your child's state of wellness and factors which may be contributing to vertebral subluxation and impeding your child's ability to heal. What signals has your child's body been communicating?

☐Asthma ☐Frequent Diarrhea ☐Failure to Thrive / Slow Weight Gain
☐Respiratory Tract Infections ☐Constipation ☐Slow or Absent Reflux
☐Sinus Problems ☐Flatulence ☐Asymmetrical Crawling or Gait ☐Ear Infections
☐Headaches/Migraines ☐Weight Challenges ☐Tonsillitis ☐Neck Pain ☐Bed Wetting
☐Torticollis/Head Tilt ☐Sleeping Problems ☐Frequent Colds/Croup ☐Trouble Nursing ☐
Night Terrors ☐Recurrent Fevers ☐Back Pain ☐Tip Toe Walking ☐Eczema ☐Growing Pains
☐Sensory Processing Issues ☐Rashes ☐Scoliosis ☐Seizures ☐Allergies ☐Red, Swollen,
Painful Joints ☐Tremors / Shaking ☐Food Sensitivities ☐Colic ☐ADD / ADHD ☐Digestive
Problems ☐Frequent Crying Spells ☐Autism
Other:_____

What is your primary goal for your child at our clinic?

_____

_____

Our goal is to provide a detailed assessment of your child's current health status and provide you with the resources for a highly engaged and healthy child whose body is functioning at its absolute peak potential while they grow. Essential to this healthy growth is a properly functioning nervous system that is able to function free from interference called subluxation.
*Dr. Kendra is certified in both pregnancy and pediatric care, is certified in the Webster Technique and is a member of the International Chiropractic Pediatric Association.

WRITTEN CONSENT FOR A CHILD

Informed Consent Regarding: Chiropractic Adjustments, Modalities, and Therapeutic Procedures: I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments. Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Copper Heights Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.
Signature of guardian _____ ____/____/____

Patient or Authorized person's Signature Date Regarding: Services Received I hereby authorize payment to be made directly to Copper Heights Chiropractic, for all benefits which may be payable under a health care plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Copper Heights Chiropractic for any and all services I receive at this office.
Signature of guardian _____ Date _____/____/____