

Falite Family Chiropractic Pediatric New Patient Questionnaire

Date: _____

Child's First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____ Age: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Parent's Work Phone: _____

Cell Phone: _____ email: _____

Mother's Name: _____ Mother's DOB: _____

Father's Name: _____ Father's DOB: _____

Names & Ages of Siblings: _____

Reason for consulting our office: _____

Referred By: _____ Relationship: _____

Previous Chiropractic Care? Y / N With whom: _____ Last Visit: _____

CIRCLE APPROPRIATELY:

Birth Place: Home / Birth Center / Hospital

Type: Vaginal / C-Section

Procedures: Forceps / Vacuum Extraction

Was delivery long? Y / N Was delivery difficult? Y / N Was labor induced? Y / N

Epidural? Y / N Pain medication? Y / N Was baby breech/in utero-constraint? Y / N

Was baby breast fed? Y / N Duration: _____

CIRCLE APPROPRIATELY:

Which Contact Sports does your child participate in:

Soccer / Football / Gymnastics / Cheerleading / Karate / Basketball / Dance /

Other: _____

According to the National Safety Council, approximately 54% of infants fall head first from a high place (bed, changing table, etc.) during their first year of life. Has this happened to your child?

____ YES ____ NO Comments: _____

List any other falls or accidents: _____

List date and year of any surgeries or hospitalizations: _____

OVER

Check any of the following conditions your child has suffered from:

- | | | |
|---|--|--|
| <input type="checkbox"/> Ear Infections | <input type="checkbox"/> A.D.D. / A.D.H.D. | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Sinus infections | <input type="checkbox"/> Temper Tantrums | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Head-Banging | <input type="checkbox"/> Colic |
| <input type="checkbox"/> Asthma / Allergies | <input type="checkbox"/> Growing Pains | <input type="checkbox"/> Digestive Problems |
| <input type="checkbox"/> Chronic Colds | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Diarrhea / Constipation |
| <input type="checkbox"/> Recurring Fevers | <input type="checkbox"/> Depression | <input type="checkbox"/> Bed-Wetting |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Mid-back Pain | <input type="checkbox"/> Low Back Pain |

Other: _____

MEDICATION

How many rounds of antibiotics has your child taken in the last 6 months? _____ Lifetime? _____

Present prescription drugs: _____

Past prescription drugs: _____

Over-the-counter drugs (Tylenol, cough syrup, laxatives, etc.): _____

FINANCIAL INFORMATION

Are you planning on using some type of insurance? Yes / No

***If you will be using insurance, please permit our office to copy your insurance card.

Primary Insured's Name: _____

Primary Insured's SSN: _____ Primary Insured's DOB: _____

Primary Insured's Employer: _____

What method of payment will you be using? cash / check / credit card

By signing below, I understand that I am ultimately responsible for the payment of the balance due for my child's care in this office.

Person responsible for account: _____

AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize Falite Family Chiropractic and its doctors to administer care as they deem necessary to my son/daughter.

Signature: _____ Relationship: _____ Date: _____