FULL LIFE
CHIROPRACTIC

New Patient Paperwork - Pediatric
Today's Date: _____

Acct #_____

Name: Birthdate: Sex: Gender:

Grade level: ☐ N/A Height: ' " Weight:

Parent(s) Name(s): No. of Siblings:

Address:

Email: Phone number:

How did you hear about us?

Who is your child's pediatrician?

Is your child seeing any other health care providers? ☐ no ☐ yes, who + for what?

Please list any medications/vitamins/herbs or other supplements that your child is taking:

Has your child seen a chiropractor before? ☐ yes ☐ no

Do you intend to submit for insurance ☐ yes ☐ no If yes, who is your carrier?

Reason for seeking chiropractic care:

☐ Improve physical symptoms ☐ Help with a difficult symptom or diagnosis ☐ Improved quality of life
☐ Improve my child's ability to respond to stressors In my life ☐ Something else:

Please use the space below to describe your child's current health concerns.
Do your best to be as thorough and complete as possible. If you do not have any symptoms and are here for wellness, please check the box below.
☐ My child does not have any symptoms, I am seeking wellness care.

What brings you into the office today?_____
When did this begin? _____
Did this start ☐ suddenly ☐ gradually ☐ after injury ☐ since birth
Has it gotten better or worse since it started? ☐ better ☐ worse ☐ same
Have you tried anything else for this? _____
Does anything make it better? _____
Does anything make it worse? _____
Anything else we should know?

What are your goals for your child's health?

1. _____
2. _____
3. _____

HEALTH HISTORY

Sleep How many hours do they sleep each night? _____ Do they wake rested? ☐ yes ☐ no
Do they have difficulty falling sleep? ☐ yes ☐ no Difficulty staying asleep? ☐ yes ☐ no
Any concerns with sleep? ☐ sleep walking ☐ night terrors ☐ other:_____
co-sleeping? ☐ yes ☐ no

Exercise/Sports Frequency: ☐ none ☐1-2x per week ☐3-5x per week ☐daily
What type of exercise/sports:

Menstrual Cycle: age of onset of menstruation:_____ ☐ does not apply

Vaccination
☐ on schedule ☐ delayed scheduled ☐ not vaccinated ☐ no longer vaccinating due to adverse reaction
was adverse reaction in child or sibling + what was the reaction? _____

Pregnancy & Conception
were there any challenges getting pregnant? ☐ yes ☐ no If yes, please explain: _____
were any fertility drugs used? ☐ yes ☐ no If yes, please explain: _____
any complications during pregnancy? _____

Childbirth
☐ membranes stripped ☐ Pitocin ☐ epidural ☐ vacuum-assist ☐ forceps ☐ no interventions
☐ vaginal ☐ c-section ☐ breech gestational age at birth: _____ weeks
How long was labor? _____ How long was active labor (pushing)? _____
Birthweight: _____ Length: _____
Any other complications?

Neonatal
☐ NICU ☐ oxygen ☐ antibiotics ☐ jaundice ☐other:
any Issues with feeding? ☐ difficulty latch ☐ low supply ☐other: _____

Developmental
milestones: at what age did the child
___ smile ___ roll ___ sit independently ___crawl ___ walk ___ run ___1st word ___ potty train ___riding tricycle,
explain delays with any of the above: _____
were/are any assistive devices used: ☐ bumbo ☐ bouncer seat ☐ walker ☐ swing

school: any social, academic, or behavioral concerns?
behavior: ☐ bed wetting ☐temper tantrums ☐ thumb sucking ☐ toe walking ☐ pica ☐ nightmares
☐other: _____

Medical History
Has child ever received medications for any Illness? If so, for what + when? _____
Has child ever had surgery or a medical procedure? If so, for what + when? _____
Has child ever broken a bone or sustained a serious fall or impact trauma? ☐ yes ☐ no
Previous hospitalizations? _____
Any known allergies? _____
How many times has your child been sick (cold/flu/sinus/ear infection) in the past year? ☐ none ☐1 - 2 times ☐ 3-5 times

Dental History
Has child been evaluated by a pediatric dentist? ☐ no ☐ yes, when? _____
Were there any abnormal findings? (cavities, tooth decay, etc.): _____
Evaluated for tongue/lip/cheek tie? ☐ yes ☐ no was correction performed? ☐ yes ☐ no when? _____

Nutrition

Feeding history: ☐ currently breastfed ☐ previously breastfed, for how long?: _____

Formula history: ☐ currently formula fed ☐ previously formula fed ☐ breastfeeding + formula ☐ never formula fed

for how long? _____ what brand:_____ any changes in formula? if so, why, when?

Age solids were started? _____ ☐ not yet

Any known allergies? ☐ corn ☐ gluten ☐ eggs ☐ dairy ☐ peanuts ☐ other:_____

What are the 3 healthiest foods your child eats? _____

What are the 3 unhealthiest foods your child eats? _____

Digestive: How frequently are bowel movements? any straining with bm? ☐ yes ☐ no

Family History *circle those that apply*

cardiac disease, hypertension, stroke, diabetes, cancer, abnormal bleeding, allergies or asthma, epilepsy, mental delay, congenital anomalies, chromosomal problems, growth problems. other: _____

Social

Who does the child live with? (one parent, both parents, grandparents, etc.): _____

What are they doing for daycare/school? _____

Thank you for taking the time to be thorough in the responses above. It will help me be more intentional with your care.

Cumulative stress has a negative impact on our body's ability to adapt to the environment.
When we can't adapt optimally, disease, dysfunction, and degeneration can result.
Please check any of the following that apply to your child.

Physical Stress	**Emotional Stress**	**Chemical Stress**
☐Birth Trauma	☐ Parents divorced	☐ Artificial Fragrances
☐Slip/Fall	☐ Stress at home	☐ Antibiotic use
☐Car Accident	☐ Mental Illness in the family	☐ Mold exposure
☐Sports Injuries	☐ Changed schools	☐ 2nd hand smoke
☐Physical Abuse	☐ Recent move	☐ Caffeine
☐Prolonged sitting	☐ Change in family dynamics	☐ Processed food
☐Poor Posture	☐ Holding in feelings	☐ "Diet/sugar-free" food
☐Heavy computer use	☐ Perfectionism	☐ Soda intake
☐Heavy phone use	☐ Procrastination	☐ Prescription/OTC medication
☐Previous Surgery	☐ Depression	☐ Junk food
☐Previous Fracture	☐ Anxiety	☐ Sugar
☐Dental procedures	☐ Worries about others	☐ Constipation

Please describe in more detail any of the *physical stressors* you checked off above: _____

Please describe in more detail any of the *emotional stressors* you checked off above: _____

Please describe in more detail any of the *chemical stressors* you checked off above: _____

Please sign below to acknowledge that the information written in this form is true and representative of your child's current state of health.

Patient name: _____

Parent/Guardian: _____ Date: _____

Notice of Privacy Practices Acknowledgement

Notice of Privacy Practices (NPP) is provided to all patients. This Notice of Privacy Practices identifies: 1) how medical information about you may be used or disclosed; 2) your rights to access your medical information, amend your medical information, request an accounting of disclosures of that information; 3) your rights to complain if you believe your privacy rights have been violated; and 4) our responsibilities for maintaining the privacy of your medical information.

initial _____ The undersigned certifies that he/she has read the foregoing, received a copy of the Notice of Privacy Practices and is the patient, or the patient's personal representative.

Informed Consent to Chiropractic Treatment

There are risks and possible risks associated with the manual therapy techniques used by doctors of chiropractic. In particular you should note:

A. While rare, some patients may experience short term aggravation of symptoms or muscle and ligament strains or sprains as a result of manual therapy techniques. Although uncommon, rib fractures have also been known to occur following certain manual therapy procedures;

B. There are rare reported cases of disc injuries identified following cervical and lumbar spinal adjustment, although no scientific evidence has demonstrated such injuries are caused, or may be caused, by spinal adjustments or other chiropractic treatment;

I acknowledge I have read this consent and I have discussed, or have been offered the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general, (including spinal adjustment), the treatment options and recommendations for my condition, and the contents of this consent.

I consent to the chiropractic treatment recommended to me by my chiropractor including and recommended spinal adjustments.

I intend this consent to apply to all my present and future chiropractic care.

Dated this _____ day of _____, 20____.

_____

Patient Signature (Legal Guardian) Witness of Signature

_____

Name Name

Photo Release

_____ I authorize Full Life Chiropractic to take pictures of my child and/or my family in the office for use on social media and/or advertising.

_____ I do not authorize Full Life Chiropractic to photograph my child or my family.