PEDIATRIC NEW PATIENT INFORMATION

Date: _____

Child's Name: _____ Child's Nickname: _____

Date of Birth: _____Age: _____ Sex assigned at birth: ☐ M / ☐ F Pronouns: _____

Child's Home Address: _____

Parent/Legal Guardian Name & Relationship to child:
_____

Phone #:_____Email: _____

Parent/Legal Guardian Name & Relationship to child: _____

Phone #:_____Email: _____

Parent's Marital Status: Married: ☐Single ☐ Divorced ☐Widowed ☐Domestic Partnership☐

List of Ages of Other Children in Family: _____

Predominant language used at home: _____

Who may we thank for referring you?
_____

PREGNANCY & BIRTH

When was the your child's due date_____ When was your child born_____

Did the mother have any complications during her pregnancy?

If yes please explain_____

Complications during labor? If yes please explain_____

Was there any complications for your child after birth? If yes please explain_____

Yes / No Has your child been diagnosed with a lip, tongue to or both _____

If yes has it been corrected please explain_____

If no are you concerned your child may have one please explain_____

NUTRITION

Yes / No Is your child being breast fed? If no, for how long was he/she breast fed? _____

If still breast-feeding, how much cow's milk does the mother consume each day? _____

Yes / No Is your child formula fed? Which formula or other milk source? _____

Yes / No Is your child eating solid food? What foods does his/her diet contain? _____

_____

What is your child's favorite food? _____

100 O'Connor Drive Suite 25, San Jose, CA 95128 www.afamilychiro.com
T: 408.271.2800 Fax: 408.271.2827

Yes / No Does your child have any food allergies_____

Yes / No Does your child have feeding difficulties?_____

Yes / No Does your child have any persistent or intermittent skin rashes?

Yes / No Is your child receiving any vitamin supplements? _____

TRAUMA

Yes / No Has your child had any recent falls or trauma? If so, describe the trauma and the date it occurred?

_____

Yes / No Has your child ever fallen down from stairs or any height? Please explain

_____

Yes / No Has your child ever been in a motor vehicle collision or near-miss? Please explain _____

Yes / No Has your child ever had a bone fracture or joint dislocation? _____

Yes / No Has your child had any other trauma or injuries? _____

Yes / No Does your child ever bang his/her head repeatedly against a wall, bed or other object? _____

GROWTH AND DEVELOPMENT

Yes / No Can your child sit unsupported? At what age did your child start to sit-up? _____months

Yes / No Is your child crawling yet? At what age did your child start crawling? _____months

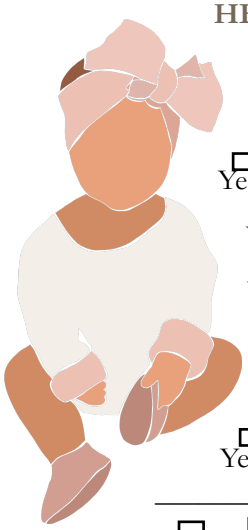
Yes / No Is your child walking yet? At what age did your child start to walk? _____months

Yes / No Does your child often trip and fall?

_____

Yes / No Do you have any other concerns about your child's growth and development?

_____



HEALTH HISTORY

Yes / No Has your child had colic? _____

Yes / No Has your child had any upper respiratory infections? How often? _____

Yes / No Has your child had asthma? _____

Yes / No Does your child ever complain about back or neck pain? _____

Yes / No Does your child ever complain of pains in arms or legs? _____

Yes / No Has your child had any earaches? At what age did the first ear ache occur? _____

Yes / No Has your child had any earaches? If yes how frequent and which ears? _____

Yes / No Has your child had any other illnesses? Please list each illness and its approximate date

_____

Yes / No Is your child presently receiving any medications? _____

100 O'Connor Drive Suite 25, San Jose, CA 95128 www.afamilychiro.com
T: 408.271.2800 Fax: 408.271.2827

☐ Yes / ☐ No Has your child ever been to a hospital or emergency room for evaluation or treatment?

If yes please explain_____

☐ Yes / ☐ No Has your child been recently vaccinated? _____

☐ Yes / ☐ No Do you have any other concerns about your child's health?

_____

CONSENT TO TREAT & POLICY

Our office policy maintains that payment is due at the time service is rendered. This includes your co-pay or deductible. Please be prompt in keeping appointments. If you need to re-schedule an appointment, kindly give us 24-hour notice, otherwise you are subject to a fee for the time we have reserved for you.

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I authorize and request my insurance company to pay directly to the chiropractor. I understand that my chiropractic insurance company may pay less than the actual bill of service. I agree to be responsible for payment of all services rendered on my behalf or dependents.

Being the parent or legal guardian of the child, I hereby authorize this office and its doctors to examine and administer care to my son/daughter named _____ as the examining/treating doctor deems necessary.

I understand and agree that I am personally responsible for payment of all fees charged by this office for such care.

Parent/Guardian's Name: _____ Signature:_____

CONSENT FOR SOCIAL MEDIA

Thank you for participating in our social media page. We wouldgreatly appreciate you filling out this form to get an understanding of how and where we are permitted to use your photographs. We plan to use these photographs as an educational and marketing tool.

I_____ hereby give permission for posting our photographs on:

(please check all that apply) ☐Facebook ☐Office ☐Instagram ☐Website ☐Newsletter ☐Yelp/ Google

AND hereby give permission for releasing the following marked information: (please check all that apply)

☐First Name ☐ Name of my Condition ☐ Image ☐Video ☐ Testimonial Quote

OR

I_____**DO NOT** GIVE PERMISSION TO POST OR USE ANY PHOTOGRAPHS/VIDEOS

Additional Comments: _____

I consent to use my videos, photographs, on the above checked off sections indicated by me and I understand thatI can always revoke this consent by contacting our office in writing.

Parent Signature:_____Date:_____/_____/_____

100 O'Connor Drive Suite 25, San Jose, CA 95128 www.afamilychiro.com
T: 408.271.2800 Fax: 408.271.2827