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? _____

SYMPTOMS

Reason for your visit _____

When did you first notice symptoms? _____

Is this condition related to an accident, previous injury, or specific cause?☐Yes / No☐

If yes explain:_____

Is this condition getting progressively worse?☐Yes / No☐

Is the pain constant or does it come and go? _____

Where specifically is the problem(s) located? _____

Which activities are difficult to perform? Sitting ☐ Standing ☐
Walking ☐ Bending ☐ Other_____

Type of pain: Sharp ☐ Dull ☐Throbbing ☐ Numbness☐ Aching☐Shooting ☐
Burning ☐Tingling ☐ Cram☐ Stiffness ☐ Swelling ☐ Other _____

Rate the severity of your pain. (1 mild pain, or discomfort, to 10 severe pain):

1 2 3 4 5 6 7 8 9 10

What treatment have you already received for your condition _____

Were X-rays taken? Yes / No If yes, what type of X-rays _____

Have you seen a chiropractor before? Yes / No Date of last visit?_____

Name the doctor who have treated you for this condition(s) _____

PLEASE MARK THE AREAS OF DISCOMFORT OR PAIN ON THE FIGURES BELOW

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

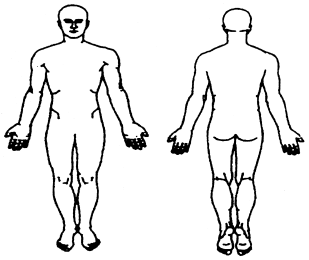
USING THE SYMBOLS THAT BEST DESCRIBES THE FEELING:

+++ Sharp or Stabbing

ooo Pins and needles

vvv Dull or aching

/ / / Numbness



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, bed, or any height?

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

If yes explain:_____

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

If yes explain:_____

Yes / No Has your child had any other trauma or injuries? If yes explain:_____

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

Yes / No Does your child often trip and fall?

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? If yes describe:_____

Yes / No Does your child ever complain of headaches? If yes how often_____

NUTRITION

Yes / No Does your child have any food allergies? _____

Yes / No Does your child suffer from Asthma? _____

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

Yes / No Is your child receiving any vitamin supplements?

_____

What foods does his/her diet contain? _____

GROWTH AND DEVELOPMENT

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? If So Please list:_____

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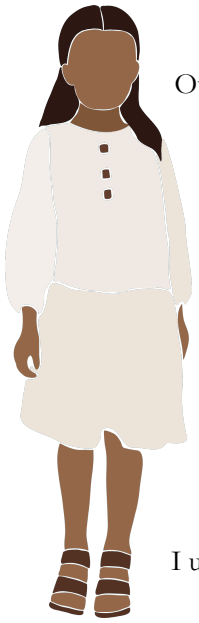
☐ Yes / ☐ No Has your child ever been to a hospital or emergency room for evaluation or treatment? If yes please explain:_____

☐ 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:_____/_____/_____