Pediatric New Patient Form

ChiropracticAlways Water Oak Suites,123 East Main Street, 202-B, Brevard, NC 28712 (828)884-5557
drnewton@chiropracticalways.com

Today's Date: _____ Can we thank someone for referring you? _____

PERSONAL INFORMATION

Name: _____ Age: _____ Date of Birth: _____ Circle: Male/Female
Address: _____ City: _____ State/Zip: _____
Home phone: ( ) _____ Cell Phone: ( ) _____
E-mail address: _____ Siblings/Ages: _____

Parent A	Parent B
Name: _____	Name: _____
Home phone: (_____) _____	Home phone: (_____) _____
Cell phone: (_____) _____	Cell phone: (_____) _____
Employer: _____	Employer: _____
E-mail: _____	E-mail: _____

PATIENT HISTORY

How can we help you?

- □ crisis management □ routine analysis and prevention
- □ maximizing normal growth & development □ other _____

Major Concern: _____ Minor Concern: _____
When/how did this/these issues begin: _____
Is this problem: □ occasional □ frequent □ constant □ intermittent
Does problem radiate? □ Yes □ No If Yes, where? _____
What makes this worse? _____
What makes this better? _____
Is the problem worse during a certain time of the day? □ Yes □ No
If Yes, when? _____
Does this interfere with the child's sleep? □ Yes □ No Eating? □ Yes □ No
Daily routine? □ Yes □ No
Is this becoming worse? □ Yes □ No
Recent tests done (list date beside): □ Bloodwork □ Urine □ X-Rays
Explain any other tests: _____
Family doctor's name: _____ Address: _____
Has your child ever received chiropractic care? □ No □ Yes
If yes, child's previous Doctor of Chiropractic: _____
The date of last visit: _____ Reason for the last visit: _____
Other professionals seen for this condition: _____
Results with any treatments? _____

FAMILY HEALTH HISTORY

Please note any hereditary health problems (i.e. cancer, diabetes, heart disease) that are present in:
Mother's family _____
Father's family _____
Siblings _____

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Often seemingly unrelated symptoms are related to one another. Please tick if your child has had any of the following:

- □ headaches
- □ dizziness
- □ irritability
- □ fatigue
- □ depression
- □ loss of balance
- □ loss of concentration
- □ fainting
- □ ears buzzing
- □ poor coordination
- □ vision changes
- □ loss of memory
- □ loss of smell
- □ loss of taste
- □ light sensitivity
- □ face flushed
- □ reduced mobility
- □ chest pressure
- □ breast pain
- □ frequent colds
- □ sinus congestion
- □ sore throats
- □ ear pain/infections
- □ asthma
- □ cold sweats
- □ bronchitis
- □ pneumonia
- □ difficulty breathing
- □ shortness of breath
- □ allergies
- □ constipation
- □ diarrhea
- □ urinary problems
- □ bloating/gas
- □ weight loss
- □ weight gain
- □ dental problems
- □ fevers
- □ heart palpitations
- □ numbness in feet
- □ numbness in hand(s)
- □ weakness
- □ heartburn
- □ muscle cramps
- □ upper back pain
- □ neck pain
- □ low back pain
- □ radiating pain
- □ sleeping problems
- □ numbness in leg(s)
- □ stiffness
- □ Other _____

BIRTH HISTORY

What was the child's gestational age at birth?
Birth weight pounds ounces Birth length inches
Was your child's birth: □ at home □ in a birthing center □hospital □other
Was the birth considered: □ medical □ midwife Duration of birth: __hours Was child born: □ cephalic (head first) □ breech (feet first)
Were there any complications? □ No □ Yes
Assistances used during delivery: □ Forceps □ Vacuum extraction □ C-section □ Episiotomy
Was labor: □ spontaneous □ induced
Were medications or epidurals given to the mother during birth? □ No □ Yes _____
APGAR scores: At Birth ___/10 After 5 minutes___/10
Is there anything else we need to know about the birth □ No □ Yes _____

GROWTH & DEVELOPMENT

Was the infant alert and responsive within 12 hours of delivery? □ Yes □ No
If no, please explain: _____
At what age did this child:
Respond to sound _____Follow Objects_____ Vocalize _____Hold head up_____
Sit alone _____ Teethe_____ Crawl_____Walk _____
Does your child sleep: □ front □side □back How many hours per day: _____

CHEMICAL STRESSORS

Was this child breast-fed? □ No □ Yes If yes, until how old: _____
Formula introduced at what age:__Which formula?_____
Introduction of cow's milk at what age:____ Began solid foods at what age:_____
Types of solid foods: _____ Any intolerances? □ No □ Yes Type:_____
Medication history, past and present: _____
During the mother's pregnancy:
Did the mother smoke? □ No □ Yes How much? _____
Drink alcohol? □ No □ Yes How much? _____
Any illnesses during the pregnancy? □ No □Yes If yes, describe: _____
Any supplements taken during pregnancy? □ No □ Yes If yes, describe: _____
Any drugs taken during pregnancy? □ No □ Yes Please list: _____
Any ultrasounds? □ No □ Yes How many:_____ Reasons for being done: _____
Any invasive procedures during pregnancy (i.e. amniocentesis, Chorionic villi sampling, etc.)? D Yes □ No
If yes, please explain _____
Any pets at home? □ No □ Yes
Any smokers in the home? □ No □ Yes
Any antibiotics given? □ No □ Yes If yes, reason: _____
Is the diet organic? □ No □ Yes Do you use 'green products' in your home for cleaning? □ No □ Yes
How often do they receive processed foods, white sugar, gluten (flour), dairy in their diet? □ Never □ Special occasions □ Weekends □ A few times per week □ Daily
Are you aware of the impact of nutrition on children's behavior? □ No □ Yes
Would you like information on nutrition for your child? □ No □ Yes

PHYSICAL STRESSORS

Chiropractors look for and can detect problems related to many types of stressors, the following information is also very important to us.

Any traumas to the mother during pregnancy? (i.e. falls, accidents, etc.) □ No □ Yes
If yes, please explain _____
Any evidence of birth trauma to the infant?

☐ stuck in birth canal □ fast or excessively long birth
☐ cord around neck □ respiratory depression
☐ bruising ☐ odd shaped head

Any falls from couches, beds, change tables, etc.? □ No □ Yes If yes, details: _____
Any traumas resulting in bruises, cuts, stitches or fractures? □ No □ Yes
If yes, please explain _____
Any hospitalizations or surgeries? □ No □ Yes If yes, please explain _____
Any sports played? _____
Is a school backpack used? □ No □ Yes If yes, how much does it weigh _____

PSYCHOSOCIAL STRESSORS

Any difficulties with lactation? □ No □ Yes Any problems with bonding? □ No □ Yes _____
Any behavioral problems? □ No □ Yes Any inattention? □ No □ Yes _____
Any hyperactivity or restlessness? □ No □ Yes Any compulsiveness? □ No □ Yes _____
Difficulties at daycare or school? □ No □ Yes Learning challenges? □ No □ Yes _____
Any night terrors, sleep walking, difficulty sleeping? □ No □ Yes _____
Any prolonged temper tantrums or separation anxiety? □ No □ Yes _____
Is the child in day care □ Yes □ No Age of child when began daycare? _____
Is there a nanny or regular sitter during the day if both parents work □ Yes □ No
Is the child home schooled? □ No □ Yes by Whom? _____
Average hours of television/week?_____ Average hours of video games per week?_____
Does your child have a cell phone? □ Yes □ No How often texting/using smartphone? _____
Do you feel that your child's social and emotional development is normal for their age? □ Yes □ No

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Thank you for completing this form. Please feel free to use the space below to add any background information you think that our questions may have missed. We invite you to discuss this information, and any other questions or concerns you may have, with the doctor.

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CONSENT FORM

Authorizing Consent for examination of a Minor (under 18 years): Please Read Carefully

In order for the health professional indicated below to make a determination on the suitability of my child's/guardian's case for care, I acknowledge and understand that a thorough evaluation must be completed. I do hereby request and consent to the performance of such an evaluation by Dr. Margaret Newton, or any party authorized by her to do so.

I have had the opportunity to discuss the nature and purpose of the examination process with Dr. Newton. I understand that I may ask the doctor to stop the examination at any time. I also understand that by signing this form, the chiropractor continues to be obligated for best practices delivered in the child's interests.

- A copy of ChiropracticAlways' "Notice of Privacy Practices for Protected Health Information (HIPAA)" brochure is available for my review both in the office and on www.chiropracticalways.com website.
- I consent to receive communication from ChiropracticAlways in connection with my child's care via email, postal mail, text and telephone messaging. If I should withdraw my consent, I will notify the office in writing.
- I consent to my child's photo or image being used in photograph or video in public media including social media, website, promotional materials. If I should withdraw my consent, I will notify the office in writing.
- It has been explained verbally and in writing that Chiropractic can sometimes have side effects or risk of ataxia, bruising, thermal injury, dislocation/subluxation, dizziness, "drop attacks", fracture, mobility disruption, paralysis, quadriplegia, spinal injury, stroke/disruption of blood flow to the brain, visual disturbances, pain, tinnitus, hallucination or death. While none of these complications have ever occurred under my care, should this happen in your case, for your protection, you would be referred immediately to another physician or appropriate health care provider for surgery or other "standards of care" treatment.
- On rare occasions side effects of massage can include bruising, inflammation, swelling and pain.
- I acknowledge that the risks of Chiropractic treatment have been explained to me verbally and in writing, I assume full responsibility for these risks.
- Should I choose detoxification as a treatment for my child with Dr. Newton, I recognize that as the body releases poisons, there may be associated memory which comes to the surface (somatic-visceral) and I agree to obtain professional council for my child upon the recommendation of Dr. Newton.
- I understand that detoxification can sometimes have side effects or risk of nausea, vomiting, diarrhea, memory recall and fainting.
- I fully understand the above Consent Form Information. I fully understand the risks and limitations of Chiropractic Care, Massage and Detoxification. I understand and fully consent to treatment with Dr. Newton for Chiropractic, Massage and Detoxification when it has been determined the care is needed. No guarantee of assurance of results has been made. I agree and intend this consent form to cover the procedures recommended in my child's case including the use of Chiropractic Care, Evaluation, Diagnosis, Adjustments, massage, Detoxification Methods, Manipulations, and treatment for any future conditions for which my child's treatment is sought.

Parent or Guardian Name:_____Date:_____

Parent/Guardian Signature:_____Witness_____