PEDIATRIC NEW PATIENT PAPERWORK

Child's Full Name:_____ Nickname:_____

Address:_____

City/State/Zip:_____

Date of Birth: _____

Height:_____

Weight:_____

Parent(s) or Guardian's Full Name:_____

Home #_____

Parent/Guardian Cell #_____

Email:_____

Reason for contacting us:_____

How did you hear about the clinic? _____

<u>Has your child had any of the following conditions:</u>

Ear Infections__ Asthma/Allergies__ Colic__ Digestive Issues__ Bed Wetting__ Seizures__ ADHD/ADD__ Chronic Cold__ Recurring Fevers__ Temper Tantrums__ Headaches__ Other:

<u>FAMILY HISTORY:</u>

Previous/Current Pediatrician:_____

Date of Last Visit:_____ Reason for Visit: _____

Other Doctor's seen for this condition? ___ If yes, please list doctor's name and prior treatments:_____

_____

_____

Number of doses of antibiotics your child has taken in the past 6 months?___

During his/her life?__

Number of doses of other perscription medications your child has taken during the past 6 months? ___

During his/her total life? ___

VACCINATION HISTORY (List vaccinations)_____

_____

FEEDING HISTORY:

Was your child breast fed? How long?___ Formula?___ How long? ___

Introduced to solids at __ months, Cow's milk at __ months

Does he/she have any food/juice allergies or intolerances?___if yes, please list:

_____

Other allergies/intollerances: _____

Number of hours sleep per night ___ Quality of sleep ____ (good, fair, poor)?

PRENATAL HISTORY:

Name of obstetrician/midwife:_____

Birth Intervention? (list type: forceps, vacuum extraction, Caesarian Section, emergency or planned): _____

Ultrasounds during pregnancy? How many? _____

Medications during pregnancy? If yes, please name them: _____

_____

Cigarette/alchohol use during pregnancy? _____

CHILDHOOD DISEASES:

Chicken Pox__ Rubeola __ Whooping Cough__ Rubella__ Mumps__

Other:_____

According to the National Safely COuncil, approximately 50% of children fall head first from a hight place during their first year of life (i.e. a bed, changing table, down stairs, etc) Was this the case with your child? ___ Please explain: _____

_____

Is/has your child been involved in an high impact or contact sports (i.e. soccar, football, gymnastics, baseball, cheerleading, martial arts, etc.)? If yes, please list: _____

_____

Has your child ever been involved in a car accident? If yes, please explain:

WE ARE HERE TO SERVE YOU, AND WE ENCOURAGE YOU TO ASK QUESTIONS. YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR RESULTS.

I hereby authorize Beyond Limits Health to administer care to my son/daughter, as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Signed: _____

Relation to Patient: _____

Date: _____