Dr. Josie Morales DC, RN

PEDIATRIC NEW PATIENT INFORMATION

Today's Date: _____

PATIENT INFORMATION

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

Reason for Visit: _____

Sex: **M** ☐ **F** ☐ Date of Birth: _____ Age: _____ Child's Home Phone #: _____

Child's Address: _____

Child's Pediatrician: _____ Pediatrician's Phone #: _____

Who may we thank for referring you? _____

FAMILY INFORMATION

Parent 1: _____ DOB: _____

Primary Phone #: _____ Secondary Phone #: _____

Email Address: _____ Update Me on Clinic Events: **Y** ☐ **N** ☐

Partner/ Parent 2: _____ DOB: _____

Primary Phone #: _____ Secondary Phone #: _____

Email Address: _____ Update Me on Clinic Events: **Y** ☐ **N** ☐

Parent's Marital Status: Married _____ Partnered _____ Single _____ Divorced _____ Widowed _____

List Ages of Other Children in Family: _____

Predominant Language Used at Home: _____

CONSENT TO TREAT

Being the parent or legal guardian of this 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.

Patient's Name: _____ Parent's Signature _____ Date: _____

Child's Name: _____ DOB: _____

PEDIATRIC HISTORY

	Y	N	
Does your child complain of pain or discomfort?	☐	☐	If yes, when did this first occur? _____
Was onset: Sudden ☐ Gradual ☐			Is Problem: Constant ☐ Intermittent ☐
Has your child ever had this problem before?	☐	☐	_____
Has your child been treated for this before?	☐	☐	If yes, by whom? _____
Has your child ever had chiropractic care?	☐	☐	Previous Chiropractor: _____

HEALTH HISTORY	Y	N	
Does your child ever complain about back or neck pain?	☐	☐	_____
Does your child ever complain about arm or leg pain?	☐	☐	_____
Does your child ever complain of headaches?	☐	☐	_____
Does your child have asthma?	☐	☐	_____
Does your child have any known allergies?	☐	☐	_____
Are there any smokers in the child's home?	☐	☐	_____
Has your child had any earaches?	☐	☐	If yes, how frequently? _____
In what ear do their earaches usually occur? R ☐ L Both			At what age did their first earache occur? _____
Is your child currently taking any medication?	☐	☐	_____
Do you have other concerns about your child's health?	☐	☐	_____

Please list any other illnesses which have been a concern for your child: _____

_____ ☐ ☐ _____

Please list any surgeries your child has had: _____

_____

TRAUMA	Y	N	
Has your child had any recent falls or trauma?	☐	☐	If yes, when did this occur? _____

Please describe what happened: _____

_____

Child's Name: _____ DOB: _____

Has your child ever:	**Y**	**N**	
Fallen from a bicycle, skateboard, scooter, rollerblades or similar?	☐	☐	_____
Fallen down stairs or fallen from a significant height?	☐	☐	_____
Been in a motor-vehicle accident or near-miss?	☐	☐	_____
Had a bone fracture or joint dislocation?	☐	☐	_____
Had any other trauma or injuries?	☐	☐	_____

Does your child ever bang their head repeatedly against a wall, bed or other object?	☐	☐	_____

NUTRITION	**Y**	**N**	
Do you have any concerns about your child's diet?	☐	☐	_____
Does your child:			
Have any food allergies?	☐	☐	_____
Have any persistent or intermittently occurring rashes?	☐	☐	_____
Take any vitamin supplements?	☐	☐	_____
Eliminate stools each day?	☐	☐	How many? _____

For how many months was your child breastfed? _____

Please list what your child usually eats for each meal.

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

How much cow's milk does your child drink each day? _____

What is your child's favorite food? _____

What types of fast food does your child like to eat? _____