Rushmore Family
CHIROPRACTIC

NAME:_____ DATE:_____/_____/_____

NEW PATIENT CHILD INFORMATION

PATIENT INFORMATION

Name: _____ Nickname: _____

Reason for Visit:_____

_____

Gender: M / F Date of Birth: _____/_____/_____ Age: _____ SSN:____-_____-_____

Home Phone: (____) ____-_____ Cell Phone: (____) ____-_____

Home Address: _____ City:_____ State: _____ Zip:_____

Parent Email Address: _____

Who may we thank for referring you? _____

School: _____ Grade: _____

Parent Name: _____ Parent Phone Number: (____) _____-_____

Emergency Contact Information

Name: _____ Relation: _____ Phone: (____) _____-_____

Insurance Information

Insurance Company:_____ Name of Primary_____

Subscriber ID #_____ Group #_____

Patient informed Consent

I, _____, the undersigned, consent to care at this clinic. I understand that I have the opportunity to discuss with the doctor and/or with other office personnel, the nature and purpose of chiropractic adjustments and progressive wellness. I hereby request and consent to performance of chiropractic procedures, including various modes of physio therapy, diagnostic x-rays, and any supportive therapies on me (or on the patient above, for whom I am legally responsible) by the doctor of chiropractic and support team at Rushmore Family Chiropractic. I also understand that as is with all healthcare treatments, results are not guaranteed, there is no promise to cure and that there are some risks. Risks include, but are limited to; aggravating and/or temporary increase in symptoms, muscle spasms, fracture, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor's judgment, based upon the facts then known, is in my best interests. I further understand that chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about this content, and by signing below I agree to above-named procedures.

Patient/Guardian Signature _____

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NAME:_____ DATE:_____/_____/_____

CHILD HISTORY OF ILLNESS/ INJURY/ PAIN

Reason for Today's visit _____

_____

When did this problem first occur? _____

Was there an accident or injury involved? ___Yes ____No If yes, describe: _____

Have you ever had this problem before?___Yes ____No If yes when? _____

Have you previously been treated for this problem? Doctor's name _____

Have you previously been to a chiropractor? ___Yes ____No
if yes when? _____
Current medications: _____

General Questions/Prenatal History:
Name of Obstetrician/Midwife:_____ Weeks Pregnant at time of delivery:_____
Location of birth (circle one): Hospital Birth Center Home
Cigarettes or alcohol during pregnancy? ____Yes ____No
Any complications during pregnancy? ___Yes ____No Explain:_____
Any complications during delivery? ____Yes ____No Explain:_____
Medications taken during pregnancy:_____
Birth Intervention (circle one): Forceps Vacuum C-Section None
If C-Section, was it: _____Emergency or _____Planned (check one)
Genetic disorders or disabilities? ___Yes ____No If yes, list:_____
Vaccinated: ____Yes ____No Adverse Vaccine Reactions: ____Yes ____No Explain:_____
Vitamin K shot: ____Yes ____No
How many times has your child been prescribed antibiotics in the past 6months?_____ Total during lifetime:_____

Feeding History:
Breast Fed: ___Yes ___No How long:_____
Formula Fed: ___Yes ___No How long:_____
Introduced to: Solids at _____Months Cow's milk at _____Months
Food Allergies or Intolerances: ____Yes ____No
List:_____

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CHILD HISTORY OF ILLNESS/ INJURY/ PAIN

Developmental History:

During the developmental times your child's spine is the most vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference). At what age was your child able to:

_____ Respond to Sound
_____ Respond to Visual Stimuli
_____ Hold Head Up Alone
_____ Sit Up Alone
_____ Cross Crawl
_____ Stand Alone
_____ Walk Alone

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (ie: a bed, changing table, downstairs, etc). Was this the case with your child? ____Yes ____No
Explain: _____

Is/has your child been involved in any high impact or contact type of sports (ie: soccer, football, gymnastics, baseball, cheerleading, martial arts, etc)? _____Yes ____No

Review of Systems

Please check if your child has had any of the following:

_____ Ear infections
_____ Allergies
_____ Colic
_____ Reflux
_____ Autism/Spectrum
_____ Seizures
_____ Scoliosis
_____ Digestive problems
_____ Growing/ back pain
_____ Tonsillitis
_____ Asthma
_____ Chronic colds
_____ ADHD/ ADD
_____Bed wetting
_____ Constipation
_____ Sleep Issues
_____ Headaches
_____ Recurring Fevers
_____ Temper tantrums
_____ Eczema/ Psoriasis
_____ Diarrhea
_____ Nursing/ Latch Issues
_____ Hip Dysplasia
_____ Postural Imbalances
_____Developmental Delays

How would you rate your child's diet?_____ Well Balanced ____Average _____High sugar/ processed foods
Does your child consume artificial sweeteners? ____Yes ____No
Number of hours your child sleeps: _____ hours per night and _____hours per day/naps
Sleep Quality: _____Good _____Fair _____Poor