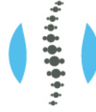

Rushmore Family
CHIROPRACTIC

PEDIATRIC NEW PATIENT INFORMATION

Date: ________________ **0-2 years old**

PATIENT INFORMATION

Child's Name: _________________________________ Child's Nickname: _______________________

Reason for Visit:____

Sex: M / F Date of Birth: _______________ Age:______ Child's SS#: _________________________

Child's Home Address:____

FAMILY INFORMATION

Mother's Name: ____________________________ Father's Name: ____________________________

Phone Number: ____________________________ Phone Number: ____________________________

Parent's Marital Status: Married ____ Single: ____ Divorced: ____ Widowed: ____

Who should we contact in case of an emergency? ____

Who may we thank for referring you? ____

INSURANCE INFORMATION

If you want us to bill insurance for your child, please fill out the following information. We will also need a copy of the insurance card. If you are planning on paying our cash price, disregard.

Insurance Company: ________________________ Name of Policy Holder: ________________________

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 physiotherapy, 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 healthcare treatments, results are not guaranteed, there is no promise to cure and that there are some risks. Risks include, but are not 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 red to me, the above consent. I have also had an opportunity to ask questions about this content, and by signing below I agree to the above-named procedures.

Patient/Guardian Signature ____

CHILD HISTORY OF ILLNESS/ INJURY/ PAIN

Reason for Today's visit ____

When did this problem first occur? ____

Has your child ever had this problem before? ___Yes ____No If yes when? ____________________________

Has your child previously been treated for this problem? Doctor's name ____

Has your child previously been to a chiropractor? ___Yes ____No
If yes, when?

____

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: Forceps Vacuum C-Section None

If C-Section, was it: ____Emergency or ______Planned

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 last 6 months?________

Total during lifetime:_________________

Any current medications? ____ Yes ____ No If yes, please list:____

Has your child ever had a fever? ____ Yes ____ No

Has your child had any falls or other trauma? ____ Yes ____ No If yes, explain:__________________________________

Rushmore Family
CHIROPRACTIC

CHILD HISTORY OF ILLNESS/ INJURY/ PAIN

Feeding History:

Breast Fed: ____Yes ____No For how long:__________

Formula Fed: ____Yes ____No For how long:__________

Does your child have a feeding side preference? _____ Yes _____ No Preferred side: Left or Right

Does your child spit-up after feeding? ____ Yes ____ No

Introduced to: solids at ______ months old cow's milk at ______ months old

Food allergies or intolerances: ____Yes ____No If yes, please list: ____

How would you rate your child's diet? ____Well Balanced _____Average ____High sugar/Processed foods

Does your child consume artificial sweeteners? ____ Yes ____ No

Sleep History:

Number of hours your child sleeps: _____ hours per night and ____ hours per day/naps

Sleep quality: ____Good ____ Fair ____ Poor

Does your child go to sleep easily? ____ Yes ____ No

Does your child have a preferred sleeping position? ____ Yes ____ No

Review of Systems

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

____Ear infections
____Allergies
____Colic
____Reflux
____Autism/Spectrum
____ADHD/ADD
____Diarrhea
____Digestive problems
____Growing/Back pains
____Tonsillitis
____Asthma
____Chronic colds
____Eczema/Psoriasis
____Constipation
____Sleep Issues
____Headaches
____Recurring Fevers
____Temper tantrums
____Scoliosis
____Nursing/Latching issues
____Hip Dysplasia
____Postural Imbala
____Developmental Delay
____ Seizures
____ Bed wetting

Do you have any other concerns you would like to discuss? ____

____