Rushmore Family
CHIROPRACTIC

PEDIATRIC NEW PATIENT INFORMATION

Date: _____ **3-5 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 _____

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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

Does your child complain of pain or discomfort? ____Yes _____No Was the onset of pain sudden or gradual? _____

Does your child complain of back or neck pain? ____ Yes ____ No

Does your child complain of pains in the legs and/or arms? ____ Yes ____ No

Does your child ever complain of headaches? ____ Yes ____ No

Are there any smokers in the child's home? ____ Yes ____ No

Is your child allergic to anything? ____ Yes ____ No If yes, please list: _____

Has your child had asthma? ____ Yes ____ No

Has your child had any earaches? ____ Yes ____ No What age did the first earache occur? _____

How frequently do the earaches occur? _____ Which ear do they usually occur in? ____ Right ____ Left ____ Both

Is your child presently taking any medications? _____

Please list any surgeries that you child has had: _____

Trauma

Has your child had any recent falls or trauma? ____ Yes ____ No Explain: _____
_____ Date Occured: _____

Has your child ever fallen from a bicycle, skateboard, scooter, or anything similar? _____ Yes _____ No

Has your child ever fallen down stairs or fallen from a significant height? ____ Yes ____ No

Has your child ever been in a motor vehicle collision or near-miss? ____ Yes ____ No

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CHILD HISTORY OF ILLNESS/ INJURY/ PAIN

Has your child ever had a bone fracture or joint dislocation? ____ Yes ____ No

Has your child had any other trauma or major injuries? ____ Yes ____ No Explain:_____

Does your child ever bang his/her head repeatedly against a wall, bed, or any other objects? _____ Yes _____ No

Review of Systems

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

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

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

_____