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## PEDIATRIC NEW PATIENT INFORMATION

Date: \_\_\_\_\_

**6-12 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 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 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**

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? \_\_\_\_\_

Does your child ever have a problem with bedwetting?  Yes  No

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

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: \_\_\_\_\_

**Review of Systems**

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

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Ear infections  | <input type="checkbox"/> Digestive problems | <input type="checkbox"/> Constipation     | <input type="checkbox"/> Bedwetting          |
| <input type="checkbox"/> Allergies       | <input type="checkbox"/> Growing/Back pains | <input type="checkbox"/> Sleep Issues     | <input type="checkbox"/> Hip Dysplasia       |
| <input type="checkbox"/> Diarrhea        | <input type="checkbox"/> Tonsillitis        | <input type="checkbox"/> Headaches        | <input type="checkbox"/> Postural Imbala     |
| <input type="checkbox"/> Reflux          | <input type="checkbox"/> Asthma             | <input type="checkbox"/> Recurring Fevers | <input type="checkbox"/> Developmental Delay |
| <input type="checkbox"/> Autism/Spectrum | <input type="checkbox"/> Chronic colds      | <input type="checkbox"/> Temper tantrums  | <input type="checkbox"/> Seizures            |
| <input type="checkbox"/> ADHD/ADD        | <input type="checkbox"/> Eczema/Psoriasis   | <input type="checkbox"/> Scoliosis        |  |

Do you have any other concerns you would like to discuss? \_\_\_\_\_

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