Tahoe Chiropractic Clinic – Family Health & Wellness

Pediatric New Patient Paperwork

Name: _____ Date:_____
Date of Birth:_____ Age: _____ Gender: M / F
Address: _____ City: _____ Zip:_____
Mother/ Guardian: _____ Father/ Guardian: _____
Phone number:_____ Phone Carrier: _____
Pediatrician: _____ Last visit: _____
Siblings—Names and Ages: _____
Who May we thank for your referral: _____

What brings your child in today? Please list in order of severity.

1.) _____
2.) _____
3.) _____
4.) _____
5.) _____

Has your child seen another health care professional for the above complaints? Y/ N? If yes, who?

_____

Birth and Delivery

Duration of pregnancy: _____ weeks Birth weight: _____
Where was your child born? Home Hospital Birthing Center Other: _____
Delivery? Vaginal / C-section C-section: Planed / Emergency
Was a device used? Y/ N Forceps / Vacuum
How long was labour? _____How long was the delivery? _____
Was oxytocin/ Pitocin administered? Y/ N Was an epidural Administered? Y / N
Birth complications? _____
Was the mother taking medications during pregnancy?
_____
Illness to mother while pregnant? _____

Infancy

Was your child vaccinated? Y / N Prolonged use of medications? _____
Circle one: Breastfed or formula? How long? _____

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Childhood years

Does your child have any childhood illnesses? _____
Sports? _____
Surgery? _____
Fallen from height over 3 feet? Y / N Car accident? Y / N
Sleep: _____hours Restful? Y / N Nightmares? Y / N

Please Circle if any of the following apply to your child.

Allergies	Sick more than peers
Asthma	Constipation
Difficulty concentrating	Ear Infections
Headaches	Colic
Bed wetting	Difficulty breastfeeding
ADHD/ ADD	Fatigue
Sleep disturbances	Torticollis
Digestive Problems	Fussy/ Irritable
Reflux	Other: _____

Parent/ Guardian Name: _____ Child Name: _____
Parent/ Guardian Signature: _____ Date: _____