CALHOUN CHIROPRACTIC
Wellness Center

NEW PRACTICE MEMBER PAPERWORK

PEDIATRIC PRE-EXAM FORM

NEWBORN – 2 MONTHS

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PEDIATRIC PRE-EXAM FORM (Newborn to 2 months)

Appointment Date: _____

Please fill out all information as thoroughly as you can. Thank you.

PERSONAL INFORMATION

Child's First Name: _____ M.I.: _____ Last Name: _____

Birth Date: _____ Age: _____ Sex: M F

Address: _____ City/State/Zip: _____

Mother's Name: _____ Father's Name: _____

Mother's Phone: ( ) _____ Father's Phone: ( )_____

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

Number of Siblings: _____ Sibling(s) Names & Ages: _____

_____

Predominant language used in home: _____

Who can we thank for referring you to our office? _____

REASON FOR SEEKING CARE

What is your reason for seeking care for your child at Calhoun Chiropractic Wellness Center? _____

_____

When did this begin? (If applicable) _____

What is this affecting most in your child's life? _____

_____

Are there any major injuries and/or surgeries we should know about? _____

_____

Has your child seen any other providers for this condition? (list all conditions and the doctor seen):_____

_____

Has your child seen a chiropractor before? ***Yes*** ***No*** If yes, how long ago? _____

Clinic/Doctor Name: _____ What is your reason for the change? _____

_____

What health goal would have the greatest impact on his/her life? _____

CONSENT TO TREAT

Who is/are the legal guardian(s) of this child? _____

Being the parent or legal guardian of this child, I hereby authorize this office and its doctors to examine, x-ray (if necessary), and administer care to my son/daughter named _____ as the examining/treating doctor deems necessary. I understand and agree that I am personally responsible for payment of all fees charged by this office for such care.

Parent/Guardian's signature: _____ Date: _____

Witnessed by: _____

PREGNANCY HISTORY

Location of birth: ○Home ○Birthing Center ○Hospital ○Other: _____

The duration of pregnancy in weeks: _____ Birth weight: _____ Birth length: _____Apgar Score: _____

Did any of the following happen during delivery: ○C-section ○Doctor pulled or twisted baby ○Anesthesia ○Labor was induced ○Forceps/vacuum extraction ○Premature delivery ○Special medical procedures/tests

Describe any of the above plus any additional complications experienced during delivery: _____

_____

What was the baby's position during pregnancy/birth? ○Anterior ○Posterior ○Breach ○Transverse ○Other_____

Did any of the following happen during pregnancy: ○Falls ○Motor Vehicle Accident ○High blood pressure ○Anemia ○Gestational Diabetes ○Morning Sickness ○Indigestion ○Seizures ○Swollen ankles ○Thyroid problems ○Heart problems ○Back pain ○Abnormal bleeding ○Any other illnesses _____

Were any of these used during the pregnancy: ○Tobacco ○Alcohol ○non-prescribed drugs ○Prescription Medications ○Over-the-counter meds ○Other: _____

Please list all medications being taken: _____

_____

Did your child receive any of the following nutrition? ○Breast milk ○Commercial formula ○Cow's milk ○Goat's milk ○Other milk ○Vitamins ○Medication ○Juice: Vegetable ○Juice: Fruit ○Other: _____

Check if you have introduced the following into the child's diet (and at how many weeks):

○Sweets _____○Solid foods_____ ○ Other_____

NEWBORN HEALTH HISTORY BIRTH TO 2 MONTHS

How many hours does your baby sleep between feedings**:** During day: _____ *hours* at night: _____ *hours*

Does your baby go to sleep easily? ○Yes ○No *If no, do you know of the cause(s):* _____

Does your baby have a preferred sleeping position? ○Yes ○ No *If yes, what positions?* _____

Does your baby cry if you change his/her sleeping position? ○Yes ○No

Does your baby have any feeding difficulties? ○Yes ○No

Is your baby being breast fed? ○Yes ○No If no, for how long was your baby breast fed? _____wks./months

Does your baby have a one-sided breast-feeding preference? ○Yes ○No If yes, which one ○Left ○Right

Is your baby formula fed? ○Yes ○No Which formula or other milk source: _____

Does your baby frequently spit up after feeding? ○Yes ○No

Does your baby cry a lot? ○Yes ○No If yes, for how many hours each day? _____ *hours*

Does your baby pass a lot of intestinal gas? ○Yes ○No How often? _____

Does your baby have a preferred head position? ○Yes ○No *If yes, explain:* _____

Does your baby frequently arch his/her head and neck backwards? ○Yes ○No

Does your baby cry or become irritable during diaper change? ○Yes ○No Has your baby ever had a fever? ○Yes ○No

Has your baby had any strains/sprains? ○Yes ○No *If yes, please explain:* _____

Has your baby been in a car accident or near miss? ○Yes ○No *If yes, please explain:* _____

Has your baby had any other trauma? ○Yes ○No *If yes, please explain:* _____

Has your baby been vaccinated? ○Yes ○No *If yes, what vaccinations?* _____

FAMILY MEDICAL HISTORY

Please check if any of your blood relatives have/had any of the following illnesses and mark accordingly by noting: M (mother), F (father), S (sibling), PMG (paternal grandma), MGM (maternal grandma), PGF (paternal grandfather), MGF (maternal grandfather):

_____Allergy ○ Have ○ Had
_____Asthma ○ Have ○ Had
_____Eczema ○ Have ○ Had
_____Cancer○ Have ○ Had
_____Low blood sugar ○ Have ○ Had
_____Heart trouble ○ Have ○ Had
_____High blood pressure○ Have ○ Had
_____Stroke○ Have ○ Had
_____Kidney disease ○ Have ○ Had
_____Liver disease ○ Have ○ Had
_____ Mental retardation ○ Have ○ Had
_____Autism ○ Have ○ Had
_____Mental illness ○ Have ○ Had
_____Scoliosis ○ Have ○ Had
_____ Ulcer ○ Have ○ Had
_____Diabetes ○ Have ○ Had

Please list all blood relatives who are deceased, the cause of death, and their age of death:

_____

_____

OTHER

Any other information or concerns about your child's health?

_____

_____

_____

_____

Acknowledgments

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials _____ **I am the legal guardian of the child noted here.**

Initials _____ **I give permission to the providers of Calhoun Chiropractic Wellness Center to provide care for my child noted in lieu of my absence.**

Initials _____ **I instruct the Doctor of Chiropractic to deliver the care that, in his or her professional judgment, can best help my child in the restoration of his/her health. I understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing from medicine and does not proclaim to cure any named disease or entity.**

Initials _____ **I may request a copy of the Privacy Policy and understand it describes how my child's health information is protected and released on my behalf for seeking reimbursement from any involved third parties.**

Initials _____ **I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my child's care in this office.**

Initials _____ **I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services my child receives.**

Initials _____ **To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my child's concern.**

Initials _____ **I understand that the doctor(s) at Calhoun Chiropractic Wellness Center will be providing my child with chiropractic treatment. I fully understand that there is no guarantee that such treatment/care will improve his/her condition(s). Many practice members have over the years been treated by chiropractors for various conditions, some of which respond to treatment, and others which may not, despite the best of care. I understand that it is my responsibility to keep an open line of communication with my doctor as to how he/she is progressing. Chiropractic treatment by nature often involves frequent office appointments in order to maximize the benefits of the care.**

Print Practice Member Name: _____ Relationship to Practice Member: _____

Parent/Guardian Signature: _____ Date: _____

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Patient Birth Records Release

I, _____, parent (or legal guardian) of the below mentioned child, hereby authorize and direct _____ to release the records relating to the birth of _____, to Calhoun Chiropractic Wellness Center noted above.
May this signed consent form be your good authority to do so.

Your Date of Birth (MM/DD/YYYY): _____/_____/_____
Your Child's Date of Birth (MM/DD/YYYY): _____/_____/_____

Your Name: _____ Date: _____

Your Signature: _____

Witness: _____ Date: _____

Thank you!

We are grateful you have chosen to bring your child to Calhoun Chiropractic Wellness Center, and look forward to being part of your family's wellness journey.