



NEW PRACTICE MEMBER PAPERWORK  
PEDIATRIC PRE-EXAM FORM  
NEWBORN – 2 MONTHS

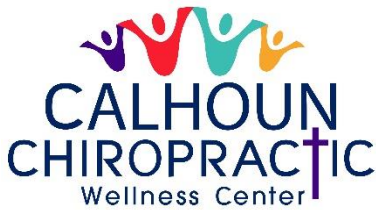
**Dr. Justin P. Calhoun, D.C.**

**Dr. Shauna B. Murphy, D.C.**

81 Victor Heights Parkway, Victor, NY 14564

**phone** 585.924.9540 | **fax** 585.924.4615

**website** <http://calhouchiropractic.net/>



81 Victor He  
phone 58  
website

## 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: \_\_\_\_\_

**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 \_\_\_\_\_

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):**

<input type="checkbox"/> Allergy <input type="radio"/> Have <input type="radio"/> Had	<input type="checkbox"/> Asthma <input type="radio"/> Have <input type="radio"/> Had	<input type="checkbox"/> Eczema <input type="radio"/> Have <input type="radio"/> Had
<input type="checkbox"/> Cancer <input type="radio"/> Have <input type="radio"/> Had	<input type="checkbox"/> Low blood sugar <input type="radio"/> Have <input type="radio"/> Had	<input type="checkbox"/> Heart trouble <input type="radio"/> Have <input type="radio"/> Had
<input type="checkbox"/> High blood pressure <input type="radio"/> Have <input type="radio"/> Had	<input type="checkbox"/> Stroke <input type="radio"/> Have <input type="radio"/> Had	<input type="checkbox"/> Kidney disease <input type="radio"/> Have <input type="radio"/> Had
<input type="checkbox"/> Liver disease <input type="radio"/> Have <input type="radio"/> Had	<input type="checkbox"/> Mental retardation <input type="radio"/> Have <input type="radio"/> Had	<input type="checkbox"/> Autism <input type="radio"/> Have <input type="radio"/> Had
<input type="checkbox"/> Mental illness <input type="radio"/> Have <input type="radio"/> Had	<input type="checkbox"/> Scoliosis <input type="radio"/> Have <input type="radio"/> Had	<input type="checkbox"/> Ulcer <input type="radio"/> Have <input type="radio"/> Had
<input type="checkbox"/> Diabetes <input type="radio"/> Have <input type="radio"/> 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.**

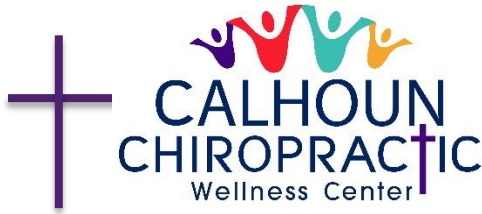
Initials \_\_\_\_\_ **I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services my child receives.**

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: \_\_\_\_\_



Dr. Justin P. Calhoun, D.C.

Dr. Shauna B. Murphy, D.C.

81 Victor Heights Parkway, Victor, NY 14564

phone 585.924.9540 | fax 585.924.4615

website <http://calhouchiropractic.net/>

## 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.**