Welcome to Newton Center Chiropractic

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PEDIATRIC NEW PATIENT INFORMATION

Today's Date_________________ Male_____ Female_____ Date of Birth_____________ Age_____________

Name: ____ Child's Nickname: _______________________________________

Ethnicity (Circle one) Hispanic or Latino / Not Hispanic or Latino Race: (Circle one) American Indian/Alaska Native/Asian Hawaiian or other Pacific Islander/black or African American/White

Reason for Visit____

Home Phone#______________________________________ Cell Phone# ____

Home Address____

Pediatrician ____ Office Phone # _____________________________________

Office Address ____

FAMILY INFORMATION

Parent 1: ____ Parent 2: ____

Home/Cell #____ Home/Cell # _______________________________________

Parent Marital Status: Married____ Single ____ Divorced ____ Widowed ____

Ages of any other children in the family____

Predominant language used at home ____

Email address: ____

CONSENT TO TREAT

Being the parent of legal guardian of this child, I hereby authorize this office and its doctors to examine and administer care to my son/daughter named _______________________________ as the examining / treating doctor deems necessary.

I understand and agree that I am responsible for payments of all fees by this office for such care.

Parent's Name: ___________________________________ Witnessed by: ___________________________________

Signature: _______________________________________ Date: ____

Whom may we thank for referring you to our office: ____

PREGNANCY HISTORY

Today's Date: _________________

Child's Name: ____ M F DOB: ______________ Age: _____________

Mother's Name: ____ How many children do you have? ___________________

What was the term of your pregnancy? : ______________ Weeks How many ultrasounds? __________________________

How Many Ultrasounds? _________ How many miscarriages? _________

DURING YOUR PREGNANCY, DID YOU HAVE ANY OF THE FOLLOWING?

	YES	NO	
Falls?	☐	☐	_______________________
Motor Vehicle Accidents?	☐	☐	_______________________
Near-Miss MVA?	☐	☐	_______________________
High Blood Pressure?	☐	☐	_______________________
Diabetes?	☐	☐	_______________________
Anemia?	☐	☐	_______________________
Morning Sickness?	☐	☐	_______________________
Indigestion?	☐	☐	_______________________
Seizures?	☐	☐	_______________________
Swollen Ankles?	☐	☐	_______________________
Thyroid Problems?	☐	☐	_______________________
Heart Problems?	☐	☐	_______________________
Back Pain?	☐	☐	_______________________
Abnormal Bleeding?	☐	☐	_______________________
Were you Hospitalized?	☐	☐	_______________________
Any other Illnesses?	☐	☐	_______________________
Had Tdap Vaccine?	☐	☐	_______________________
Had Flu Shot?	☐	☐	_______________________

DURING YOUR PREGNANCY, DID YOU USE ANY OF THE FOLLOWING?

	YES	NO
Tobacco?	☐	☐
Alcohol?	☐	☐
Prescription Drugs?	☐	☐
☐ Over-the-Counter-Meds?	☐	☐
Recreational Drugs?	☐	☐

BIRTH HISTORY	LABOR AND DELIVERY

How long was the labor from the first regular contractions to the birth? _____________hours

How long was the pushing phase of the labor? _______________hours

	YES	NO	
Hospital Birth (Hospital Name)?	☐	☐	______________________
Home Birth?	☐	☐	______________________
Midwife Assisted?	☐	☐	______________________
Vaginal Delivery?	☐	☐	______________________
Planned C-Section?	☐	☐	______________________
Emergency C-Section?	☐	☐	______________________
Was Birth Induced?	☐	☐	______________________
Forceps Delivery?	☐	☐	______________________
Vacuum Extraction?	☐	☐	______________________
IV Fluids?	☐	☐	______________________
Anesthesia Administered?	☐	☐	______________________
Antibiotics?	☐	☐	______________________
Fetal Distress?	☐	☐	______________________
Meconium Staining?	☐	☐	______________________
Cord Wrapped Around Neck?	☐	☐	______________________
Head Presentation?	☐	☐	______________________
Face Presentation?	☐	☐	______________________
Breech Presentation?	☐	☐	______________________

BABY'S CONDITION IMMEDIATELY AFTER BIRTH

Apgar Scores: At 1 Minute: ___________1/10 At 5 Minutes: ____________1/10

Baby's Crying: Cried Immediately After Birth ☐ Cried Strongly ☐ Weak Cry ☐ Didn't Cry for ______ minutes

Baby's Color: Pink All Over ☐ Blue Face ☐ Blue Hands/Feet ☐

Baby's Activity: Arms and Legs Actively Moving ☐ Floppy Baby ☐

Intensive Care: Was Required ☐ Days in Neonatal Care Unit ________

Medication Given at Birth? _________________________________ **Vaccines Administered** ______________________________

Birth Weight __________ lbs./kg **Birth Length**: ________ins/cms **Baby Home on Day**: __________________

Current Weight _________ **Current Length**: __________

NEWBORN HISTORY

The following questions are designed to help the doctor provide the best possible spinal care for your child.

How many hours does your baby sleep between feeds? During Day: _________ At Night: _______

	YES	NO	
Does your baby go to sleep easily?	☐	☐	____________________
Does baby have a preferred sleeping positions?	☐	☐	____________________
Does baby cry if you change the sleeping position?	☐	☐	____________________
Does baby have any feeding difficulties?	☐	☐	____________________
Is baby being breastfed? (if no, for how long?)	☐	☐	____________________
Does baby have a one-sided breastfeeding preference?	☐	☐	____________________
Is baby formula fed? (Which formula or milk source?)	☐	☐	____________________
Does baby frequently spit-up after feeding?	☐	☐	____________________
Does baby cry a lot? (For how many hours each day?)	☐	☐	____________________
Does baby pass a lot of intestinal gas?	☐	☐	____________________
Does baby have a preferred head position?	☐	☐	____________________
Does baby frequently arch their head & neck backwards?	☐	☐	____________________
Does baby cry or become irritable during diaper change?	☐	☐	____________________
Has baby ever had a fever?	☐	☐	____________________
Has baby had any falls?	☐	☐	____________________
Has your baby had any other trauma?	☐	☐	____________________
Has your baby been vaccinated?	☐	☐	____________________
Do you swaddle your baby?	☐	☐	____________________

DEVELOPMENTAL MILESTONES

⁕Please indicate only the ***most complex*** skills that your child can perform in each section. (Should be 1 per section)

In each section, the tasks are arranged in order of increasing developmental age.

GROSS MOTOR SKILLS

☐Able to hold head up from the table momentarily

☐Head and should can be supported by the forearms

☐Infant can be pulled up into a sitting position by the hands

☐Sits unsupported in the upright position

☐Head and shoulders supported by the arms

☐Rolls from prone to supine position

☐Crawls

☐Stands holding onto furniture

☐Walks unassisted

☐Runs

☐Negotiates stains placing 2 feet on each step

☐Climbs stairs using one foot on each step

☐Walks down stairs with one foot on each step

☐Hops on one foot

SOCIAL SKILLS

☐Smiles

☐Reaches for familiar objects

☐Plays with hands

☐Plays with feet

☐Clearly shows joy and pleasure

☐Feeds self with fingers

☐Plays peek-a-boo

☐Understands yes and no

FINE MOTOR SKILLS

☐Primitive grasp reflex

☐Holds and shakes a rattle placed in hand

☐Grasps objects independently

☐Moves an object from on hand to the other

☐Self feeding, can hold and eat a cookie

☐Checks objects by placing them in the mouth

☐Picks up object with thumb and index finger

☐Turns 2 to 3 pages of a book at a time

☐Turns pages of a book one at a time

☐Builds a tower containing at least 5 blocks

COMMUNICATIONS SKILLS

☐Makes cooing sounds

☐Laughs

☐Uses one syllable words such as “da”

☐Uses 2 syllable words such as “dada”

☐Uses 2 to 3 word vocabulary

☐Uses 2 to 3 word phrases

ADAPTIVE SKILLS

☐Holds own bottle

☐Feeds from cup unassisted

☐Feeds self with utensils

☐Able to identify and match some colors

☐Copies a circle

☐Copies a cross

INFANT HISTORY	*** 2 MONTHS TO 2 YEARS***

The following questions are designed to help the doctor provide a detailed evaluation of your child.

NUTRITION	**YES**	**NO**	
Is your child still being breastfed? If no, for how long?	☐	☐	________________
If yes, how much cow's milk does the mother consume each day?	☐	☐	________________
Is your child formula fed? Which formula or other mils source?	☐	☐	________________
Is your child eating solid foods? (Which foods)	☐	☐	________________
What is your child's favorite food?	☐	☐	________________
Does your child have any feeding difficulties?	☐	☐	________________
Does your child have any digestive disturbances?	☐	☐	________________
Does your child have any food allergies?	☐	☐	________________
Does your child have any persistent or intermittent skin rashes?	☐	☐	________________
Is your child receiving and vitamin supplements?	☐	☐	________________

TRAUMA			
Has your child had any recent fall or trauma?	☐	☐	________________
Describe the trauma and the date it occurred	☐	☐	________________
Has your child ever fallen down the stains or fallen from any height?	☐	☐	________________
Has your child ever been in a motor vehicle collision or near miss?	☐	☐	________________
Has your child ever had a bone fracture or joint dislocation?	☐	☐	________________
Has your child had any other trauma or injuries?	☐	☐	________________
Does your child ever bang their head repeatedly against a wall, bed or other object?	☐	☐	________________

Additional comments:____

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INFANT HISTORY ***2 MONTHS TO 2 YEARS***

GROWTH AND DEVELOPMENT

	YES	NO	
Can your child sit unsupported?	☐	☐	
Is your child crawling yet? (At what age did they start?)	☐	☐	____________________
Is your child walking yet? (At what age did they start?)	☐	☐	____________________

Do you have any concerns about your child's growth and development?____________________

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____

Does your child often trip and fall?	☐	☐	____________________

HEALTH HISTORY

Has your child had colic?	☐	☐	____________________
Has your child had any upper respiratory infections? (How often?)	☐	☐	____________________
Has your child had asthma?	☐	☐	____________________
Does your child ever complain of back or neck pain?	☐	☐	____________________
Does your child ever complain of pains in the arms or legs?	☐	☐	____________________
Does your child ever complain of headaches?	☐	☐	____________________
Has your child had any earaches? (At what age did 1st occur?)	☐	☐	____________________
How frequently does your child have earaches?			____________________
Do the earaches usually tend to occur in the same ear? Right, left or borth?	☐	☐	____________________
Has your child had any other illnesses?	☐	☐	____________________
Please list each illness and approximate date.			____________________
Is your child presently receiving any medications?	☐	☐	____________________
Please list them			____________________
Has your child recently been vaccinated?	☐	☐	____________________
Has your child ever been to a hospital or ER for evaluation or treatment?	☐	☐	____________________

Do you have any other concerns about your child's health?

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