

# Van Every Family Chiropractic Center, PLC

4203 Rochester Rd. • Royal Oak, MI 48073 • (248) 616-0900

## Pediatric New Patient Information: Birth - 2 Years Old

Child's Name \_\_\_\_\_ Date \_\_\_\_\_  
Last First Middle Initial

Nickname \_\_\_\_\_ Gender \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Mother's Name \_\_\_\_\_ Father's Name \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_

Parent's Marital Status:  Married  Single  Divorced  Widowed Email \_\_\_\_\_

Insured's Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Insurance Company \_\_\_\_\_

List names and ages of other children in family \_\_\_\_\_

Reason for today's visit \_\_\_\_\_

When did this problem first occur? \_\_\_\_\_ Have they ever had this problem before?  Yes  No

Have they previously been treated for this problem?  Yes  No Doctor's Name \_\_\_\_\_

Has your child previously had chiropractic care?  Yes  No Doctor's Name \_\_\_\_\_

Whom may we thank for your referral? \_\_\_\_\_

### ~ PLEASE CHECK ALL THAT APPLY ~

#### DURING PREGNANCY

- Falls
- Car accidents
- Back pain
- Headaches
- Any other complications (list):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

#### LABOR & DELIVERY

- Hospital birth
- Home birth
- Vaginal delivery
- Planned C-section
- Emergency C-section
- Birth induced
- Forceps delivery
- Vacuum extraction
- Fetal distress
- Breech
- Bruised head
- Cone shaped head
- Misshapen head
- Other complications

#### CURRENT HEALTH

- Spits up frequently
- Cries a lot
- Passes a lot of gas
- Vaccinations
- Skin rashes
- Colic
- Frequently arches head/neck back
- Cries/irritable during diaper change
- Neck pain
- Back pain
- Leg pain
- Arm pain
- Upper respiratory infections
- Ear infections:  Right or  Left
- Headaches

Was your child ever breast fed?  Yes  No If yes, how long did you breast feed your child? \_\_\_\_\_ OR  Still breast feeding

If currently breast feeding, is there a preference for one breast over the other?  Left  Right  No Preference

List any **recent falls or trauma**: \_\_\_\_\_

List all **surgeries or fractures** and when: \_\_\_\_\_

List all **medications** and what they're being used for: \_\_\_\_\_

Do you have any other concerns you wish to discuss? \_\_\_\_\_

### CONSENT TO TREAT

Being the parent or legal guardian for 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.

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

