

Van Every Family Chiropractic Center, PLC

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

Pediatric New Patient Information: 3 - 10 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 ~

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Neck pain | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Shooting head pains | <input type="checkbox"/> Fainting or seizures | <input type="checkbox"/> Acid reflux or ulcers | <input type="checkbox"/> Tailbone / sacrum pain |
| <input type="checkbox"/> Sinus trouble | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Painful joints |
| <input type="checkbox"/> Loss of smell - taste | <input type="checkbox"/> Ringing of ears or earaches | <input type="checkbox"/> Stomach trouble | <input type="checkbox"/> Swollen joints |
| <input type="checkbox"/> Hayfever / Allergies | <input type="checkbox"/> Hearing difficulty | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Hip pain |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Eye / vision trouble | <input type="checkbox"/> Nerves, nervousness | <input type="checkbox"/> Pinched nerve in back |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Neck muscle spasm | <input type="checkbox"/> Irritability - moodiness | <input type="checkbox"/> Pins & needles in legs |
| <input type="checkbox"/> Throat trouble | <input type="checkbox"/> Tightness in shoulder muscles | <input type="checkbox"/> Bladder problems | <input type="checkbox"/> Swollen ankles |
| <input type="checkbox"/> Infections | <input type="checkbox"/> Pain in shoulders & arms | <input type="checkbox"/> Kidney trouble | <input type="checkbox"/> Cold feet |
| <input type="checkbox"/> Sleeping trouble | <input type="checkbox"/> Pins & needles in arms & hands | <input type="checkbox"/> Buttocks pain | <input type="checkbox"/> Numbness in legs |
| <input type="checkbox"/> Facial pain or palsy | <input type="checkbox"/> Cold hands | <input type="checkbox"/> Low back pain | <input type="checkbox"/> Knee pain |
| <input type="checkbox"/> Loss of memory | <input type="checkbox"/> Chest pains or rib pains | <input type="checkbox"/> Constipation | <input type="checkbox"/> Groin pain |
| <input type="checkbox"/> Chronic fatigue | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Pain in legs and feet |
| <input type="checkbox"/> Depression / anxiety | <input type="checkbox"/> Heart palpitation or heart trouble | <input type="checkbox"/> Digestive problems | |
| <input type="checkbox"/> Stress | <input type="checkbox"/> Upper back pain | <input type="checkbox"/> Problems w/bedwetting | |
| <input type="checkbox"/> Dizziness / vertigo | <input type="checkbox"/> Mid back or shoulder blade pain | <input type="checkbox"/> Skin rashes | |

Family history of any of the above? Yes No If yes, who? _____

Has your child: Been vaccinated? Yes No Been in a motor vehicle accident? Yes No If yes, when: _____

Does your child play sports? Yes No If yes, please list: _____

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:** _____

