Whom may we thank for referring you to this office → ___________________________________

PEDIATRIC APPLICATION FOR CARE AT NEW JOURNEY CHIROPRACTIC

Today's Date: __________________

Patient Information

Child's Name: ____________________________________Birth Date: _____-_____-_____ Age: _______ ☐ Male ☐ Female

Parent/ Guardian name(s): ____

Address: _____________________________________ City: ______________________________ State: _____ Zip: ______

E-mail Address: _________________________________ Home Phone: __________________Mobile Phone:_____________

Siblings Names and Ages ____

Previous Chiropractic Care ☐ No ☐ Yes

If Yes, what was their reason for visit? _______________________________________

Name of Previous Chiropractor: ____________________________

How long were you under care: ___________ What were the results? ____

Emergency Contact

Name ____ Relationship to child : _________________________________

Phone Number__________________________________ Alternate Phone Number:______________________________

Family Doctor

Name____ Clinic Name____

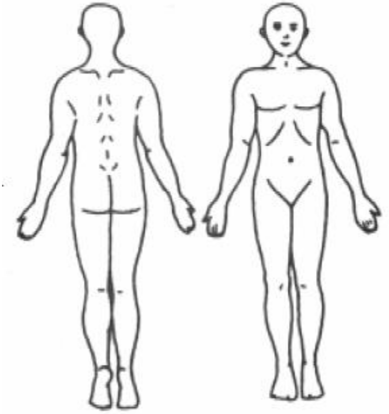
When where they last seen _________________________Reason for visit____

Why have you decided to have your child evaluated by a Chiropractor?

☐ He/ She is continuing care from another chiropractor
☐ Recently had my spine checked and understand the value in getting my child checked
☐ He/ She has a specific condition and I've learned that chiropractic may be able to help
☐ Want to help support my child's immune function
☐ Have concerns about his/her health and I'm looking for answers

What is your specific concern(s) that brings you in to our office today? ____
Does your child appear to be in pain or discomfort? ☐No ☐Yes
How long has your child been experiencing this? _____________________
Is it getting better, worse or staying the same? _________ Was the onset sudden or gradual? ______________
Have you seen other health professionals regarding this complaint?
☐No ☐Yes, whom? ____
What treatment(s) did they use? ____
Has your child taken medication for this complaint? . . . . ☐No ☐Yes ____________________
Has your child ever experienced this complain before? . . . . ☐No ☐Yes ____________________
Did they receive any treatment at the time? . . . . ☐No ☐Yes ____________________
Has your child had x-rays in relation to the current complaint? . . . . . . ☐No ☐Yes ____________________

***PLEASE MARK** the areas on the Diagram with the following **letters** to describe your symptoms:
R = Radiating **B = B**urning **D = D**ull **A =** Aching **N = N**umbness **S = S**harp/ **S**tabbing **T= T**ingling



What relieves your child's symptoms? ____

What makes your child's symptoms feel worse? ____

LIST RESTRICTED ACTIVITY *(Jumping, Running, Walking)* ______________________________________

CURRENT ACTIVITY LEVEL ____

USUAL ACTIVITY LEVEL ____

What additional signals has your child been communicating?

CURRENT	PREVIOUS		CURRENT	PREVIOUS		CURRENT	PREVIOUS	
☐	☐	Asthma	☐	☐	Frequent Diarrhea	☐	☐	Failure to Thrive / Slow Weight Gain
☐	☐	Respiratory Tract Infections	☐	☐	Constipation	☐	☐	Slow or Absent Reflexes
☐	☐	Sinus Problems	☐	☐	Flatulence	☐	☐	Asymmetrical Crawling or Gait
☐	☐	Ear Infections	☐	☐	Headaches/Migraines	☐	☐	Weight Challenges
☐	☐	Tonsillitis	☐	☐	Neck Pain	☐	☐	Bed Wetting
☐	☐	Strep Throat	☐	☐	Torticollis/Head Tilt	☐	☐	Sleep Problems
☐	☐	Frequent cols/Croup	☐	☐	Trouble Feeding on One Side	☐	☐	Night Terrors
☐	☐	Recurrent Fevers	☐	☐	Back Pain	☐	☐	Tip Toe Walking
☐	☐	Eczema	☐	☐	Growing Pains	☐	☐	Regression of Milestones
☐	☐	Rashes	☐	☐	Scoliosis	☐	☐	Seizures
☐	☐	Allergies	☐	☐	Red, Swollen, Painful Joint	☐	☐	Tremors / Shaking
☐	☐	Food Sensitivities	☐	☐	Colic	☐	☐	ADD / ADHD
☐	☐	Digestive Problems	☐	☐	Frequent Crying Spells	☐	☐	Autism / PPD

Prenatal Profile

☐ Adopted ☐ Prenatal history unknown ☐ Birth history unknown

Any Maternal Illness during pregnancy: ☐No ☐Yes *(brief description)* ________________________________

Number of previous pregnancies ______________

Complications during pregnancy: ☐No ☐Yes *(brief description)* ____________________________________

Ultrasounds during pregnancy: ☐No ☐Yes, if so, how many? ______________________________________

Medications during pregnancy: ☐No ☐Yes ____

If so, which ones and how often? *(Include OTC)*: ____

Exposure to alcohol, cigarettes or secondhand smoke during pregnancy: ☐No ☐Yes ___________________

Birth Experience

Location of Birth: ☐Home ☐Hospital ☐Birthing Center ☐Other ________________________

Birth Attendants: ☐Doula ☐Midwife ☐GP ☐OB ☐Other_______________________________

Medications during labor / delivery *(including IV antibiotics)* ☐No ☐Yes _____________________________

Was Pitocin used to induce / speed up labor? ☐No ☐Yes

Were your membranes ruptured by a medical professional? ☐No ☐Yes

Birth Experience (continued)

Was your child at any time during your pregnancy in an intra-uterine constraining position? ☐No ☐Yes ☐Unsure
If yes, please describe: ☐Breech ☐Transverse ☐Face / Brow presentation
Was your delivery vaginal or C-section? ___________ If it was C-section, was it planned or emergency? ______________
If it was vaginal, was the baby presented: ☐Head ☐Breech *(circle one)* Face or Forehead Presentation
Were any of the following interventions used during delivery? ☐Forceps ☐Vacuum Extraction ☐Other ___________
Were there any complication during delivery? ☐No ☐Yes
If yes, please specify: ____
How long was the labor from first regular contractions to the birth? ________ Hours
How long was the second stage (the pushing phase) of the labor? _________ Hours
Was the baby born with any purple markings / bruising on their face or head? ☐No ☐Yes
Did your baby have jaundice? ☐No ☐Yes, what treatments were used? _________________________________
Any concerns about misshapen head at birth? ☐No ☐Yes

Post Natal & Infant History

How many weeks gestation was the baby at birth? ___ w___ d / Birth weight: ___ lbs___ oz / Birth Length ____ inches
If known, APGAR scores at: 1 minutes ______ / 10 5 minutes ______ / 10
Was the baby ever administered to Neonatal Intensive Care? ☐No ☐Yes
If yes, for how long and why? ____
Were there any medication/vaccine(s) given to the baby at birth? ☐No ☐Yes ☐Unsure
If yes, what medication and why? ____
Was your child exclusively breastfed? ☐No ☐Yes ______ months
Did your child have any tongue ties or prefer nursing to one side? ☐No ☐Yes ______________________________
Was your child breastfed + formula fed? ☐No ☐Yes ______ months
Was your child formula fed? ☐No ☐Yes ______ months Brand _________Was it imported formula? ☐No ☐Yes
Did your child show any sensitivities to formula (reflux, eczema, arching back, frequent spit up)? ☐No ☐Yes
What age did you introduce solid foods to your child? ______ months
Did you introduce cereal or grains within your child's first year? ☐No ☐Yes
Did/Do you practice attachment parenting methods: ☐No ☐Yes
(i.e. co-sleeping, kangaroo care, elimination communication, feeding on demand, extended breastfeeding, etc.)
Did your child spend excess time in any baby devices such as: bouncer seats, swings, bumbos, car seats, etc?
☐No ☐Yes, if so, which ones? ____

Physical Traumas

Has your child ever fallen from any high places? . . . . ☐No ☐Yes ____________________
Has your child ever been involved in a motor vehicle accident or near miss? . . . . .☐No ☐Yes ____________________
Has your child been seen on an emergency basis? . . . .☐No ☐Yes ____________________
Has your child broken any bones? . . . .☐No ☐Yes ____________________
Has your child had any previous hospitalizations? . . . . ☐No ☐Yes ____________________
Has your child had any previous surgeries? . . . .☐No ☐Yes ____________________
Does your child spend time using a tablet, computer or video games? . . ☐Never ☐Rarely ☐Daily ☐Severalhrs/day
Does your child watch tv?. . . . .☐Never ☐Rarely ☐Daily ☐Severalhrs/day
Does your child exercise? . . . .☐No ☐Daily ☐Weekly ☐Seasonally
Does your child play contact sports?. . . . .☐No ☐Daily ☐Weekly ☐Seasonally
Does your child sleep on their . . . .☐Back ☐Belly ☐Sides (both, right, left)
Does your child carry a back pack?. . . . .☐ No ☐Yes
Does it weigh less than 15% of their body weight? . . . . ☐ No ☐Yes ☐Unsure
Do they wear their back pack on 2 shoulders? . . . .☐No ☐Yes ☐Sometimes
Does your child show excessive or uneven shoe wear? . . . .☐No ☐Yes
Does your child wear custom orthotics? ☐No ☐Yes, for what purpose? ______________________________

Chemical Stressors

Have you chosen to vaccinate your child? ☐No ☐Yes, on a delayed or selective schedule ☐Yes, on schedule
Reason for vaccination: ☐Informed decision ☐Didn't know I had a choice ☐It was recommended
Reaction(s) to vaccination: ☐Fever ☐Welt at injection site ☐Rash ☐Diarrhea ☐Fatigue ☐Prolonged Cry ☐Seizures ☐Developmental Regression ☐Other________________________
Does your child receive annual flu shots? ☐No ☐Yes (informed decision) ☐Yes (recommended by MD)
Has your child been exposed to antibiotics? ☐No ☐Yes
If yes, how many doses in the past 6 months? ______ Reason ____
Were probiotics used at the same time as the antibiotics? ☐No ☐Yes
Has your child been exposed to medications, including OTC? ☐No ☐Yes
If yes, which ones? ____
If yes, how many doses in the past 6 months ______ Reason ____
How many glasses of water/day does your child have? . . . . ☐0 ☐1-3 ☐4-6 ☐7-9 ☐10+
How many glasses of cow's milk, juice and soda/day does your child have? . . . . ☐0 ☐1-3 ☐4-6 ☐7-9 ☐10+
Does your child eat gluten? . . . . ☐No ☐Yes ☐Trying to eliminate from diet
Does your child eat dairy? . . . . ☐No ☐Yes ☐Trying to eliminate from diet
Does your child eat refined sugars (white sugar), white bread and pasta? ☐No ☐Yes ☐Trying to eliminate from diet
Does your child eat boxed/frozen foods? . . . . ☐No ☐Yes ☐Trying to eliminate from diet
Do you choose organic foods? ☐No ☐Yes If yes, which ☐Veggies ☐Fruits ☐Meats ☐Grains ☐All
Does your child eat any artificial sweeteners like Splenda, Aspartame, AminoSweet, Diet Soda? ☐No ☐Yes
Does your child follow any other dietary restrictions? ☐No ☐Yes ____
Any food/drink allergies, sensitivities, intolerances? ☐No ☐Yes ____
Is your child exposed to secondhand smoke? ☐No ☐Yes ____
Does your child take a probiotic daily? ☐No ☐Yes ______ CFU's/day
Does your child take vitamin D3 daily? ☐No ☐Yes ______ IU's/day
Does your child take Omega 3 Fish Oils daily? ☐No ☐Yes ______ mg/day ☐Capsule ☐Liquid
Other supplements or homeopathic remedies? ____

Goals & Consent

Do you feel your child is developmentally appropriate for their age?
Intellectually: ☐Yes ☐No ____
Emotionally: ☐Yes ☐No ____
Physically: ☐Yes ☐No ____

What is your primary goal for your child at our clinic? ____

Our goals are to provide a detailed assessment of your child's current health status and provide to you the resources for a highly engaged and healthy child whose body is functioning at its absolute peak potential while they grow. Essential to this is healthy growth is nervous system functioning free from interference called subluxations.

You've taken an important step in your child's future through a chiropractic evaluation. ☺

Consent to Evaluation of a Minor Child

I __________________________________ being parent or legal guardian of ____________________________________,
(print name of consenting adult) (print name of minor)

Hereby grant permission for my child to receive a chiropractic evaluation including history, spinal scan, examination and x-rays if warranted. Any findings will be communicated before consenting to commencement of treatment, if appropriate.

____ ____________________________________
Consenting Adult's Signature Date