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How did you hear about our office? ____

New Patient Paperwork (Pediatric)

Today's Date: _______/_______/__________

Patient Name: ____

Date of Birth: _______/_______/__________ ☐ **Male** ☐ **Female**

Address: ____ **Apartment #** _______

City: ______________________________ **State:** ______________ **Zip Code:** ________________

Parent/Guardian's Name: ____

Date of Birth: _______/_______/__________ **Social Security #:** __________ - ________ - ___________

Relationship to Patient: ☐ **Parent (Natural)** ☐ **Parent (Adoptive)** ☐ **Step-Parent** ☐ **Legal Guardian**

Parent/Guardian Phone: (Mobile) ______________________________ **(Home)** ___________________________

Parent/Guardian E-Mail Address: ____

Parent/Guardian's Name: ____

Date of Birth: _______/_______/__________ **Social Security #:** __________ - ________ - ___________

Relationship to Patient: ☐ **Parent (Natural)** ☐ **Parent (Adoptive)** ☐ **Step-Parent** ☐ **Legal Guardian**

Parent/Guardian Phone: (Mobile) ______________________________ **(Home)** ___________________________

Parent/Guardian E-Mail Address: ____

What is the name of the patient's Pediatrician/Family Doctor? _________________________________

Pediatrician/Family Doctor's Address: ____
City: __________________________________ **State:** ___________ **Zip Code:** ____________
Phone #: _________________________________
When did the patient last see their Pediatrician/Family Doctor?: ______________________________
What was the reason for the visit?: ____

HISTORY OF COMPLAINT

Why is the patient being seen in our office today?

☐Wellness Check-up/Yearly Spinal Exam ☐Injury or Accident ☐Other___________________________________

Is the patient currently experiencing pain/discomfort? ☐ Yes ☐ No
If yes, please describe where: ____

When did the problem first begin? ____

Was the onset of the problem ☐ Gradual? ☐ Sudden? Or ☐ Unknown

How would you describe the problem at the current time?

☐ Rapidly Improving ☐ Gradually Worsening

☐ Gradually Improving ☐ Rapidly Worsening

☐ Constant/Consistent ☐ On & Off

Has the patient ever had this problem before? ☐ Yes ☐ No If yes, when?: ________________________________

Has the patient experienced any bowel or bladder issues since this problem began? ☐Yes ☐No
If yes, please describe: ____

Have you taken the patient to see any other doctors regarding this problem? ☐ Yes ☐ No
If yes, please provide the doctor's information: Name: ____
Address: ____
____
____
Phone #: ____
When did the patient last see the doctor listed above?: ____
What type of treatment did the patient receive and what were the results?_________________________________
____

Has the patient taken any medication (prescription or over-the-counter) for this problem? ☐ Yes ☐ No
If yes, what kind?: ____

Has the patient ever suffered an injury from playing sports? ☐ Yes ☐ No
If yes, please describe what sport and type of injury: ____
____

Has the patient ever been injured due to an auto accident? ☐ Yes ☐ No
If yes, when did the accident occur and what type of injury was sustained?: ________________________________
____

Please check any symptoms that the patient has ever had (even before the current problem):

☐ Headaches ☐ Seizures/Convulsions ☐ Sinus Trouble

☐ Orthopedic Problems ☐ Leg Problems ☐ Poor Posture

☐ Digestive Disorders ☐ Reflux ☐ Hypertension

☐ Behavioral Problems ☐ Muscle Pain ☐ Asthma

☐ Dizziness ☐ Heart Trouble ☐ Scoliosis

☐ Neck Problems ☐ Joint Problems ☐ Anemia

☐ Poor Appetite ☐ Constipation ☐ Colds/Flu

☐ ADD/ADHD ☐ Growing Pains ☐ Walking Trouble

☐ Fainting ☐ Chronic Earaches ☐ Bed Wetting

☐ Arm Problems ☐ Back Aches ☐ Colic

☐ Stomach Aches ☐ Diarrhea ☐ Broken Bones

☐ Hernia/Ruptures ☐ Allergies to _______________ ☐ Sleeping Problems

☐ Fall from:

☐ Bed ☐ Bicycle ☐ Changing Table

☐ Crib ☐ High Chair ☐ Monkey Bars

☐ Couch ☐ Slide ☐ Skates

☐ Swing ☐ Stairs

I understand that I am directly and fully responsible to Living Well Chiropractic of Central Florida for all fees associated with chiropractic care my child receives.

The risks associated with exposure to ionization and spinal adjustments have been explained to me to my complete satisfaction, and I have conveyed my understanding of these risks to the doctor. After careful consideration I do hereby request and authorize imaging studies and chiropractic adjustments for the benefit of my minor child for whom I have the legal right to select and authorize health care services on behalf of.

☐ (PLEASE CHECK ONLY IF THIS STATEMENT APPLIES TO YOU): Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other guardian is not required. If my authority to so select and authorize this care should change in any way, I will immediately notify this office.

Parent/Guardian Signature: ____ **Date:** ______________

Doctor's Signature Upon Review: ____ **Date:** ______________