NYGREN CHIROPRACTIC & ACUPUNCTURE

CHILD NEW PATIENT FORM

PERSONAL INFORMATION:

Child's Name _____ DOB: _____ Age: _____ Sex: M F
Address_____City_____State_____Zip_____
Parent's Information: Cell #: _____ Email:_____ Referred By:_____
Marital Status: S M D W Name of Spouse_____Number of children_____
Emergency Contact: Name_____Relationship_____Phone (_____)_____-_____
Child's Health Care Providers: Pediatrician: _____Last seen for:_____
Chiropractor: _____ Last seen for:_____
Massage Therapist: _____ Last seen for:_____
Acupuncturist/Other:_____ Last seen for: _____

PRESENT CONDITION:

Is this a ___ Wellness Visit or here for a ___ Specific Concern?
Primary reason for your child's visit today:_____
This began: Date_____ How?(Include history with details)_____
_____
Describe the pain: __ Sharp __Dull __Ache __Pinch __Throb __Shooting __Burning __Tingle __Numb __Random __Constant ___On & Off ___Other: _____ Radiate/travel to other body parts? _____
Is this auto accident related? Yes_____ No_____ Current Litigation? Yes_____ No_____
Previous tests or treatments for this problem:_____
_____
Rate your pain: 1(least) to 10 (most severe)___ This problem occurs?___Hourly ___Daily ___Weekly ___Monthly
List anything that makes it worse: _____
_____Time of day it's worse: _____
List anything that makes it better :_____
_____Time of day it's better:_____
Is your child's condition interfering with their: __Play __Sleep __Eating __Exercise ___Other:_____
What are the most important activities you want your child to regain?_____
Where do you rate your child's overall health now? Sick- 1 2 3 4 5 6 7 8 9 10 -Healthy
I would like the following treatment(s) for my child's complaint:
___Chiropractic ___Acupuncture ___Supplement Program ___ Cold Laser ___Open to all

PRENATAL HISTORY:

Pregnancy Complications:_____Number of Ultrasounds?_____
Medications During Pregnancy_____Cigarette/Alcohol Use During Pregnancy?__Y__N
Location of Birth:__Hospital__Home Birth Intervention:__Induced __Forceps__Vacuum Extraction__C-Section
Meds during Delivery: __Pitocin __Epidural __Other Explanation_____
Birth Weight_____Genetic Disorders or Disabilities: _____Jaundice?_____

FEEDING HISTORY (if 5 yrs. old or under):

Breast Fed__Y__N How long?_____Formula Fed__Y__N How long?_____Type:_____
Difficulty latching on?_____Food Intolerances__Y __N List_____

CASE HISTORY:

Surgeries and hospitalizations with dates:_____
Current prescription medications and what they are for:_____
Current vitamins/herbs and what they are for:_____
Family history of cancer, diabetes or heart illness? Y N Please list:_____

☑ Please check areas of stress that apply to your child, either in the past (P) as well as current (C).

P	C	Physical Stress
		Birth Trauma
		Fall on head
		Car Accidents
		High Contact Sports
		Physical Abuse
		Poor Posture
		Sleep on stomach
		Heavy Backpack
		Continuous sitting/standing
		Bone Fractures
		Surgery

P	C	Emotional Stress
		Relationships/Siblings
		Children
		Homework
		High Stress
		Hold in Feelings
		Quick Tempered
		Verbal Abuse
		Perfectionist
		Sickness/loss of loved one
		Self Esteem
		Other

P	C	Chemical Stress
		Second hand
		Poor diet
		Caffeine—amount?
		Excessive Sugar
		Processed/Fast Food
		Artificial Sweeteners
		Soda
		Antibiotics
		Prescription Meds
		Over the counter meds
		Other

☑ **What symptoms has your child been experiencing? P = Past C= Current**

P	C	
		Acid Reflux
		ADHD
		Allergies
		Asthma
		Anxiety
		Bed wetting
		Bladder Problems
		Colds (frequent)
		Chronic Sinus

P	C	
		Colic
		Cough
		Diarrhea/Constipation
		Dizziness/Vertigo
		Ear infections
		Epilepsy
		Food Sensitivities
		Growing Pains
		Headaches

P	C	
		Scoliosis
		Seizures
		Skin Conditions
		Stomach Aches
		Tongue Tie
		Torticollis
		Temper Tantrums
		Vaccine Reaction
		Other

AUTHORIZATION FOR CARE OF A MINOR:

I hereby authorize this office and its Doctor to administer care to my Son/Daughter as they deem necessary.
I clearly understand and agree that I am personally responsible for payment of all fees charged by this office

Printed Patient Name: _____ Printed Parent/Guardian Name: _____

Parent/Guardian Signature:_____ Date: _____