Whom may we thank for referring you to this office → _____?

PEDIATRIC APPLICATION FOR CARE AT ELITE CHIROPRACTIC

(Infancy through Adolescence)

Today's Date: _____

Is the patient now, or will he / she be eligible for Medicare/Medicaid in the next 6 months? ☐ Yes ☐ No

PATIENT DEMOGRAPHICS

Patient's Name: _____ Birth Date: _____-_____-_____ Age: _____ ☐ Male ☐ Female

Social Security #: _____ **Grade of School:** _____

Address: _____ City: _____ State: _____ Zip: _____

E-mail Address: _____ Home Phone: _____Mobile Phone:_____

Mother's Name: _____ Mother's Mobile: _____ DOB ____/___/_____

Father's Name: _____ Father's Mobile: _____ DOB ____/___/_____

Parents are: ☐ Married ☐ Separated ☐ Divorced ☐ Living Together ☐ Other: _____

Name of Emergency Contact: _____ Relationship: _____

E-mail Address: _____ Home Phone: _____Mobile Phone:_____

Referred by another physician: ❑ Yes ❑ No

Referring Physician's Name: _____ Last Visit: ___/___/_____ Specialty: _____

Phone: _____ Address: _____ City: _____ State: _____ Zip: _____

Pediatrician/Family MD _____ ☐ **N/A** Last Visit: ___/___/_____

Phone: _____ Address: _____ City: _____ State: _____ Zip: _____

Previous Chiropractor _____ ☐ **N/A** Last Visit: ___/___/_____

Phone: _____ Address: _____ City: _____ State: _____ Zip: _____

Other Physician _____ ☐ **N/A** Last Visit: ___/___/_____ Specialty: _____

Phone: _____ Address: _____ City: _____ State: _____ Zip: _____

HISTORY of COMPLAINT

☐ Wellness Check-Up ☐ Injury or Accident ☐ Other: Please explain: _____

Present Weight: _____ Present Height/Length: _____

List the health concerns in order of importance:	How long has he/she had it?	Seen another doctor for this complaint?
1. _____	_____	❑ Yes ❑ No Date: ___/___/_____
2. _____	_____	❑ Yes ❑ No Date: ___/___/_____
3. _____	_____	❑ Yes ❑ No Date: ___/___/_____
4. _____	_____	❑ Yes ❑ No Date: ___/___/_____

If your child is experiencing Pain/Discomfort, please identify where and how long:
On a scale of **1** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by c***ircling the number*.**

Primary or chief complaint is : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Second complaints is : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Third complaint: : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Fourth complaint: : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

When did the problem(s) begin? ☐ Specific Date: ___/___/_____ ☐ Unknown ☐ Gradual ☐ Sudden

When is the problem at its worst? ☐ AM ☐ PM ☐ mid-day ☐ late PM

How long does it last? ☐ It is constant **OR** ☐ I experience it on and off during the day **OR** ☐ It comes and goes throughout the week

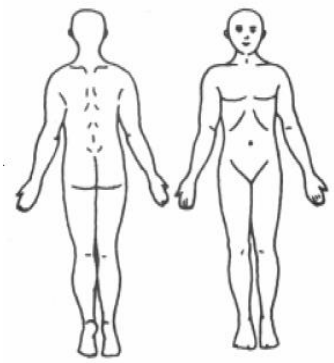
Is the problem the result of ANY type of accident? ☐ Yes, ☐ No, If 'Yes', ☐ Motor Vehicle ☐ Work ☐ Other

How did the injury happen?_____

Condition(s) ever been treated by anyone in the past? ☐No ☐ Yes **If yes,** when: _____ by whom? _____

How long were they under care: _____ What were the results? _____

***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 the symptoms? _____

What makes them feel worse? _____

Other Complaints:

Ear Infections?	❑ Currently	❑ Never	❑ Past, **how many total?** _____
Colds?	❑ Currently	❑ Never	❑ Past, **how many total?** _____
Strep Throat?	❑ Currently	❑ Never	❑ Past, **how many total?** _____
Hearing Deficit?	❑ Currently	❑ Never	❑ Past, **how many total?** _____
Vision Deficit?	❑ Currently	❑ Never	❑ Past, **how many total?** _____

Any speech impediments: ❑ Currently ❑ Never ❑ Past

Learning impediments: ❑ Currently ❑ Never ❑ Past

Typical Day's Diet:

Breakfast: _____

Snack: _____

Lunch: _____

Snack: _____

Supper: _____

Snack: _____

REVIEW OF SYSTEMS

Regarding the next section, **please circle Yes (Y), No (N) or Past (P)** regarding the following:

EYES		HEAD		NOSE	
Dry/Watery	Y N P	Headache	Y N P	Frequent Colds	Y N P
Double Vision	Y N P	Migraine	Y N P	Chronic Congestion	Y N P
Glaucoma	Y N P	Past Head Injury	Y N P	Polyps	Y N P
Dark Under Eyelids	Y N P	Hair Loss	Y N P	Nosebleeds	Y N P
Cataracts	Y N P	Dandruff	Y N P	Post Nasal Drip	Y N P
Styes	Y N P	Oil/Dry Hair	Y N P	Seasonal Allergies	Y N P

SKIN		MOUTH/ THROAT		RESPIRATORY	
Rash	Y N P	Canker Sores	Y N P	Cough	Y N P
Hives	Y N P	Sore Throat	Y N P	Wheezing	Y N P
Psoriasis/eczema	Y N P	Odd Taste	Y N P	Bronchitis	Y N P
Dry	Y N P	Chronic Dry Mouth	Y N P	Pneumonia	Y N P
Skin Cancer	Y N P	Cold Sores	Y N P	Asthma	Y N P
Abnormal Perspiration	Y N P	Gum Disease	Y N P		
Itchy	Y N P	Cavities	Y N P	Shortness of Breath:	
Warts/Moles	Y N P	Hoarseness	Y N P	with exertion	Y N P
		Swollen Glands	Y N P	at rest	Y N P

URINARY TRACT		GASTROINESTINAL		CARDIOVASCULAR	
Incontinence	Y N P	Diarrhea	Y N P	High Blood Pressure	Y N P
Frequent Infections	Y N P	Constipation	Y N P	Low Blood Pressure	Y N P
Urgency	Y N P	Heartburn	Y N P	Arrhythmias	Y N P
Discharge / Blood	Y N P	Indigestion	Y N P	Edema (swelling)	Y N P
Kidney Stones	Y N P	Bloating	Y N P	High Cholesterol	Y N P
		Nausea/Vomiting	Y N P	Murmurs	Y N P
Do you get up to urinate at night?	1x 2x 3x more	Recent BM Change	Y N P	Palpitations	Y N P
		Hemorrhoids	Y N P	Chest Pain	Y N P
		Gall Bladder Disease	Y N P		

MUSCULOSKELETAL		NERVOUS SYSTEM		EMOTIONAL HEALTH	
Weakness	Y N P	Paralysis	Y N P	Depression	Y N P
Stiffness	Y N P	Tingling/Numbness	Y N P	Suicidal	Y N P
Tremors	Y N P	Seizures	Y N P	Anxiety	Y N P
Arthritis	Y N P	Sciatica	Y N P	Eating Disorder	Y N P
Leg Cramps	Y N P	Carpal Tunnel Syndrome	Y N P	Anger/Irritability	Y N P
Pain	Y N P	Fainting	Y N P	High-Strung/Tense	Y N P
				Fear/Panic	Y N P
				Psychiatric Hospitalization	Y N P

MALE GENETALIA

Testicular Pain/Swelling	Y N P	Discharge	Y N P	Sexually Active	Y N P
				STD	Y N P

FEMALE GENETALIA

Age Periods Began	_____	Last Pap Smear (month/yr)	___/_____	Sexually Active	Y N P
How long Period Lasts	_____	Any Abnormal Paps	Y N P	Vaginal Dryness	Y N P
Menstrual Cramping	Y N P			Vaginal Itching/Irritation	Y N P
PMS	Y N P	Times Pregnant	_____	STD	Y N P
How Often Period Occurs	_____	How many births	_____	Vaginitis	Y N P
Heavy Menstrual Bleeding	Y N P	Miscarriages	Y N P	Mammography	Y N P

Current Method of Birth Control: _____

Hormonal Birth Control Used in the Past and How Old You Were: _____

PAST HISTORY

Pregnancy: Mother's age at conception: _____ Did she have other children already? ❑ Yes ❑ No
Duration of Pregnancy: (weeks) _____ Length of Labor: _____ hours
Mother's Health During Pregnancy
Smoking: ❑ Yes ❑ No ❑ Some
Diabetes: ❑ No ❑ Gestational ❑ Type I ❑ Type II ❑ Type III
Coffee: ❑ Yes ❑ No ❑ Some
Nausea/Vomitting: ❑ Yes ❑ No ❑ Some
Preeclampsia: ❑ Yes ❑ No

Birth: Was the birth: ❑ Vaginal ❑ Cesarean Section ❑ Forceps ❑ Suction
Length of Labor: _____ hours
Traumatic birth: ❑ Yes ❑ No
Complications during your birth: ❑ Yes ❑ No If "yes" please explain:_____
_____
_____

Infancy: Was the baby breastfed? ❑ Yes ❑ No For how long: _____
Was the baby put on formula: ❑ Yes ❑ No What formula was used: _____
When was child put on solid food: _____

Vaccination: (Yes, has had; No, has not; Some, did not finish all shots)

MMR:	❑ Yes	❑ No	❑ Some	DPT:	❑ Yes	❑ No	❑ Some
Hep B:	❑ Yes	❑ No	❑ Some	Hib:	❑ Yes	❑ No	❑ Some
Chickenpox:	❑ Yes	❑ No	❑ Some	Polio:	❑ Yes	❑ No	❑ Some

Any reactions to vaccinations? ❑ Yes ❑ No ❑ Unknown
Please explain: _____
_____
_____

Estimated number of rounds of antibiotics:
As an Infant: _____
As a Child: _____
In the Last Year: _____

Have you ever taken probiotics? (L. acidophilus, B. bifidum)
❑ Yes ❑ No
If "Yes", please list: _____
_____

PREVIOUS SURGERIES AND HOSPITALIZATIONS

1. _____ Date Occurred: _____ Outcome: _____
2. _____ Date Occurred: _____ Outcome: _____
3. _____ Date Occurred: _____ Outcome: _____

KNOWN ALLERGIES
(medications, environment, foods)

1. _____ Last Date Occurred: _____ Severity: _____
2. _____ Last Date Occurred: _____ Severity: _____
3. _____ Last Date Occurred: _____ Severity: _____

MEDICATIONS

Antacids ❑ Yes ❑ No ❑ Previously **Over-the-Counter Pain Meds.** ❑ Yes ❑ No ❑ Previously
Steroids ❑ Yes ❑ No ❑ Previously

Current prescription or over the counter medications (please attach additional paper if needed)

Medication and Dose	Reason Prescribed	Prescriber	Length of Time Taking This Medication	Side Effects Experienced
1.				
2.				
3.				
4.				

SOCIAL HISTORY

EXERCISE

How often does he/she exercise: _____
What types of exercise? _____
For how long? _____

Hobbies: _____

SLEEP

How long per night? _____

If the child wakes up frequently, for what reason?
_____
_____

Sleep Walk	❑ Yes	❑ No	❑ Previously
Grind Teeth	❑ Yes	❑ No	❑ Previously
Nightmares	❑ Yes	❑ No	❑ Previously
Wake Refreshed	❑ Yes	❑ No	❑ Previously
Must Nap	❑ Yes	❑ No	❑ Previously

DIET

What special diet does the child follow, if any?
❑ Vegetarian ❑ Vegan ❑ Food Allergy ❑ Atkins
❑ Other: _____

What does the patient drink during the day, how much?
❑ Coffee _____ ❑ Soda _____ ❑ Juice _____
❑ Tea _____ ❑ Water _____ ❑ Other _____

Eating Habits (check any that apply):
❑ Skip Breakfast ❑ Crave sweet
❑ 3 meals per day ❑ Crave salt
❑ 2 meals per day
❑ Graze (small, frequent meals)
❑ Eat constantly whether hungry or not
❑ Generally eat on the run

TOXIN EXPOSURE

Has the child ever lived near any refinery, polluted area? ❑ Yes ❑ No
Has the child ever lived in a home with lead paint? ❑ Yes ❑ No
Has the child ever lived in a home that had new carpeting, paint, new cabinets or did other refurbishing? ❑ Yes ❑ No

Does the patient seem particularly sensitive to perfumes, gasoline or other vapors? ❑ Yes ❑ No _____

FAMILY HISTORY:

	Father	Mother	Siblings	Paternal Grandfather	Paternal Grandmother	Maternal Grandfather	Maternal Grandmother
Age if living	_____	_____	_____	_____	_____	_____	_____
High Blood Pressure	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Heart Attack / Stroke	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Heart Disease	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Asthma / Allergies	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Mental Illness	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Auto-Immune	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Diabetes	Y N	Y N	Y N	Y N	Y N	Y N	Y N

I understand that I am directly and fully responsible to Elite Chiropractic for all fees associated with chiropractic care my child receives.

The risks associated with 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 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.

❑ 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.

_____ _____ _____/____ /_____
Patient's Name **Guardian's Name** **Date Completed**

_____ _____
Patient or Guardian's Signature **Relationship to Patient**

_____ _____ - _____ - _____
Doctor's Signature **Date Form Reviewed**