126 Center Street Suite B7 Jupiter, FL 33458 Ph: 561.277.9087

Jupiter Family CHIROPRACTIC

Pediatric New Patient Application

Child's Name_____

Name of Parent(s)/Guardian(s)_____

Address _____ City _____State _____Zip_____

Home Phone_____ Work/ Cell Phone_____Email Address_____

Birth Date _____ Sex_____ Weight_____ Height_____ Number of siblings_____

Who may we thank for referring you? _____

Reason for seeking chiropractic care:_____

Other Doctors seen for this condition Y/N Specialty: _____

Prior treatment and outcome: _____

Other Health Problems: _____

Symptoms: Please check any current or past problems your child has on the list below:

_Dizziness	_Allergies	_Diarrhea	_Broken bones
_ADHD	_Runny Nose	_Poor Appetite	_Sprains/Strains
_Backaches	_Itchy Eyes	_Hyperactivity	_Hernias
_Heart Condition	_Rashes	_Behavioral	_Neck Pain
_Chronic Earaches	_Unusual Moles	_Poor Memory	_Arm/Elbow Pain
_Diabetes	_Neuritis	_Insomnia	_Leg/Hip Pain
_Tuberculosis	_Digestive	_Nightmares	_Knee/Foot Pain
_Hypertension	_Sinus Trouble	_Bed Wetting	_Growing pains
_Fever/Chills	_Cough/Wheeze	_Pain Urinating	_Joint Pain
_Frequent Colds	_Chest Pain	_Convulsions	_Scoliosis
_Arthritis	_Constipation	_Paralysis	_Blood disorders
_Headaches	_Anemia	_Muscle Pain	_Stomach Aches
_Asthma	_Rheumatic Fever	_Fainting	_Other

Health History:

Name of Pediatrician: _____ Date of last visit _____

Medications and conditions being treated: _____

Has your child ever taken antibiotics? ◯ Yes ◯ No Condition treated: _____

Has your child been injured participating in contact sports (Soccer, Football, Martial Arts…) ◯Yes ◯ No

If yes, describe (Sprain, Broken Bone, Head Trauma…) _____

Has your child ever been involved in a car accident? ◯ Yes ◯ No

If yes, when and what injuries occurred?_____

Other traumas not described above? Y/N Type & Date: _____

Prenatal History

Location of Birth: O Home O Birthing Center O Hospital O Stepchild O Adopted

Complications during pregnancy: ◯ Yes ◯ No If yes, please explain: _____

Ultrasounds during pregnancy: ◯ Yes ◯ No If yes, how many?_____

Medications during pregnancy: ◯ Yes ◯ No List: _____

Cigarette / Alcohol use during pregnancy: ◯ Yes ◯ No

Birth intervention: O Forceps O Vacuum O Caesarian

Complications during delivery: ◯ Yes ◯ No If yes, please explain: _____

Genetic disorders or disabilities: ◯ Yes ◯ No If yes, please explain: _____

Birth weight_____ Birth length_____

Feeding history

Breast Fed: ◯ Yes ◯ No How long?_____ Formula fed: ◯ Yes ◯ No How long?_____

Type:_____ Introduced to solids at _____ months. Cow's milk at _____ months.

Food / juice allergies or intolerances ◯ Yes ◯ No If yes, please list: _____

Developmental History

Sleep (hours/night) _____ Naps (number & lengths) _____Problems sleeping _____

At what age was your child able to: Crawl ___ Sit alone____ Stand alone____ Walk alone____ Say words ___

Vaccination History:

O HBV / Hep B (Hepatitis B) – Age _____ O MMR (Measles, Mumps, Rubella) – Age _____

O DTP or O DTaP (Diphtheria, Tetanus, Pertussis) – Age _____ O Varicella (Chicken Pox) – Age _____

O HbCV / Hib (H. influenzae type b conjugate) – Age _____ O PCV (Pneumoccocal) – Age _____

O OPV (Oral Polio Vaccine) or O IPV (Inactivated Poliovirus) – Age _____

Adverse Reactions to Any Vaccine? Y/N List: _____

Insurance

Do you have medical insurance? ◯ Yes ◯ No Insurance Company Name_____

***Please provide our staff with your insurance card and picture ID so that we may provide a complimentary Chiropractic benefits check.*

Method of payment for first visit:
◯ Cash ◯ Check ◯ Credit/ Debit Card ◯ HSA (Health Savings Account)

The above information is true and accurate to the best of my knowledge. My reason for consultation with the doctor is for evaluation of my physical health and the potential for improvement.

Patient or Guardian Signature: _____ ***Date:*** _____/_____/_____