DERRY CHIROPRACTIC

NEW PEDIATRIC PATIENT INFORMATION

Child's Name: ______________________________ Age: _____ Date: ___ - ___ - ____

Address: ______________________________ City: ____________ State: ___ Zip: ______

Mother's Name: ______________________ Father's Name: ______________________

Phone #:( ) ____ - _____ SSN#: ____ - ___ - ______ Birth Date: ___ - ___ - _____ ☐Male ☐ Female

Reason for consulting our office: ______________________________

Whom may we thank for referring you? ______________________________

ISSUES / CONDITIONS THAT BROUGHT YOU TO THIS OFFICE

If your child has no symptoms or complaints, and is here for wellness services, please check ☐;

Others please briefly describe the chief area of complaint, including the effect it has on the child.

____

If he/she is experiencing pain, it is: ☐Sharp ☐Dull ☐Comes and Goes ☐Travels ☐Constant

Since the problem started, it is: ☐About the same ☐Getting better ☐Getting worse?

What makes it worse? ______________________________

It interferes with: ☐School ☐Sleep ☐Walking ☐Sitting ☐Hobbies ☐Other__________

Other doctors seen for this problem:

☐ Chiropractor: Name: ______________________________

☐ Medical doctor: Name: ______________________________

☐ Other: Name: ______________________________

List medications the child is taking or surgeries the child has had:

1) ______________________________

2) ______________________________

3) ______________________________