Pediatric Application for Care
Birth to Age 11

RESTORE FAMILY CHIROPRACTIC

Is this appointment alone or with a family member?

◯ Family Member (same day) ◯ Family Member (different day) ◯ Alone

Biological Sex:

◯ M ◯ F

Confidential Personal Information

Child's Name: _____

Date Of Birth: _____

Address _____

City/State/zip _____

How many Siblings? _____ Ages? _____

Primary Care Physician _____

Parent/Guardian: _____

Cell: _____

Other Phone _____

Email _____

Contact Person: ◯ Mom ◯ Dad ◯ Other _____

Preferred Contact Method: ◯ Text me ◯ Call me

Currently seeing any other health care providers? _____

Do any other family members have an appointment?

☐ Yes, in the same week as mine ☐ Yes, I was referred by them ☐ No, but I'd like to schedule them ☐ No, but let's talk about that later

Who is responsible for all charges arising from Today's Appointment?

◯ Mom ◯ Dad ◯ Other _____

How did you hear about us?

◯ Referral from Current Patient ◯ Google search ◯ Facebook/Instagram ◯ I saw you at an event

◯ Midwife / Primary Care Provider ◯ I saw your sign ◯ Other: _____

Health Goals for your Child

What is the purpose of today's appointment?

◯ Wellness Checkup ◯ Recent injury or accident ◯ My child has other current or recent symptoms

What are your top 3 health goals for your child?

1. _____
2. _____
3. _____

Has your child ever seen a chiropractor before: ◯ Yes ◯ No If yes, where? _____

When was your last visit? _____ Did they take Xrays? ◯ Yes ◯ No

Hospitalizations and Surgeries (include year): _____

Significant injuries, accidents, or falls (include year): _____

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How Can We Help?

If your child is experiencing symptoms, what are they? _____

When did they start? _____

Have they experienced this before? ◯ Yes ◯ No When? _____

Have they received treatment for this? ◯ Yes ◯ No When? _____

What diagnosis did they receive, if any? _____ Where? _____

Birth and Pregnancy

Did the mother experience any complications during pregnancy?

◯ Back Pain ◯ Gestational Diabetes ◯ Pre Eclampsia ◯ Strep B

◯ Fatigue ◯ Swelling ◯ Nausea ◯ Other

Your child was born or experienced (Mark all that apply):

Time: ◯ Less than 36 weeks ◯ 36-40 weeks ◯ 40+ weeks ◯ Other

Location: ◯ Birthing Center ◯ At home ◯ Hospital ◯ Epidural

Type: ◯ Vacuum/Forceps ◯ Caesarean ◯ Normal/Vaginal

Complications:

◯ Extended Hospitalization ◯ Jaundice ◯ Congenital Anomalies ◯ Antibiotics

◯ Respiratory Distress ◯ Breech ◯ Failure to Thrive ◯ Extended Labor

Infant Feeding: ◯ Breast ◯ Formula ◯ Bottle

Did you have any concerns around your child's development, including low or high weight or delays in reaching developmental milestones? _____

Symptom Review

Does your child experience any of these symptoms?

☐ Headaches	☐ Arm/Hand Problems	☐ Muscle Pain
☐ Dizziness	☐ Backaches/Neck aches	☐ Allergies
☐ Bed Wetting	☐ Leg/Foot Problems	☐ Allergies
☐ Fainting	☐ Poor Posture	☐ Seizures
☐ Seizures	☐ Irritability/depression	☐ Scoliosis
☐ Heart Trouble	☐ Digestive Problems	☐ Low Energy
☐ Chronic Earaches	☐ Trouble Sleeping	☐ Constipation
☐ Sinus Trouble	☐ Frequent cold/flu	☐ Diarrhea
☐ History of Falls	☐ Growing Pains	☐ Anemia
☐ Orthopedic Problems	☐ Ruptures/Hernias	☐ ADD/ADHD
☐ Broken Bones	☐ Hyperactivity	☐ Delayed Development

Parent/Guardian Signature: _____ Date: _____