

R. Tyler Given, D.C.
Family Chiropractor

Pediatric New Patient Information

Child's Name _____ Nickname or Preferred Name _____

Home Phone (_____) _____ Cell/Other Phone (_____) _____

Address _____ City _____ State _____ Zip _____

Age _____ Birth Date _____ Parent's Names _____

Referred by _____

Health Information

Purpose of this visit

No symptoms. I would like my child's spine checked.

Symptoms (describe) _____

Other doctors seen for this condition _____

Has your child been treated for any health condition during the past year? Yes No

Describe _____ Date of last physical exam _____

List any medications or drugs taken _____

List any surgeries _____

List any serious illnesses _____

List any serious falls or accidents _____

Labor and Delivery Information

Length of labor and delivery _____ Were forceps used? Yes No Vacuum extractor? Yes No

C-section? Yes No Breech delivery? Yes No Birth injuries? Yes No

Any newborn problems? Yes No If yes, describe _____

Check any symptoms or problems your child has had or is having

- | | | |
|--|--|---|
| <input type="checkbox"/> Spinal Curvature | <input type="checkbox"/> Allergies/Asthma | <input type="checkbox"/> Colic |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Ear infections | <input type="checkbox"/> Respiratory infections |
| <input type="checkbox"/> Neck pain or stiffness | <input type="checkbox"/> Poor immune response | <input type="checkbox"/> Skin problems |
| <input type="checkbox"/> Upper or mid back pain or stiffness | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Heart problems |
| <input type="checkbox"/> Arm pain or numbness | <input type="checkbox"/> Learning disorders | <input type="checkbox"/> Poor posture |
| <input type="checkbox"/> Low back pain or stiffness | <input type="checkbox"/> Bed wetting | <input type="checkbox"/> Growing pains |
| <input type="checkbox"/> Leg pain or numbness | <input type="checkbox"/> Stomach or digestive problems | <input type="checkbox"/> Other _____ |

Additional information _____

Payment is expected at the time services are provided

Do you have chiropractic insurance benefits? Yes No Don't Know

I understand and agree that I am personally responsible for professional services rendered to my child.
If insurance is involved, I authorize Dr. Given to release any information needed to process my claim.

Parent or Guardian's Signature Authorizing Care _____ Date _____

Information Taken By _____ Date _____