Activate Chiropractic
A Family Wellness Center

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

( ) Spinal Curvature	( ) Allergies/Asthma	( ) Colic
( ) Headaches	( ) Ear infections	( ) Respiratory infections
( ) Neck pain or stiffness	( ) Poor immune response	( ) Skin problems
( ) Upper or mid back pain or stiffness	( ) Sinus problems	( ) Heart problems
( ) Arm pain or numbness	( ) Learning disorders	( ) Torticollis
( ) Low back pain or stiffness	( ) Bed wetting	( ) Growing pains
( ) Leg pain or numbness	( ) Stomach or digestive problems	( ) 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. Libby to release any information needed to process my claim.

Parent or Guardian's Signature Authorizing Care _____
Date_____

Information Taken By _____
Date_____