

PEDIATRIC NEW PATIENT FORM

Patient's Name _____ Date _____
 Age _____ Date of Birth _____
 Parent/Guardian Name _____ Relationship to Patient _____
 Address _____ City _____
 State _____ Zip _____ Home Phone _____
 Cell Phone _____ Email _____
 Preferred method of contact? (circle) Home Phone Cell Phone Email

CHIEF COMPLAINT

What is the main reason that you are seeking care for your child? Please list any injuries, accidents, trauma, or illnesses that are related to this complaint:

Where does your child complain of pain or discomfort?

How often is your child experiencing these symptoms?

When is it worse & better? _____

Have you given them anything for relief? _____

Has your child seen anyone else for this condition? _____

Has your child ever had chiropractic care before? _____

Birth & Prenatal History: Please Circle Your Answers

Birth Place: Home Hospital Birth Center Midwife
Type of Delivery: Vaginal C-Section
Interventions: Forceps Vacuum Extraction Epidural

Complications during delivery: _____

Medications during delivery: _____

If breast fed, did the child nurse equally on both sides? Yes No

Health History:

Any allergies or intolerance to foods, medications, etc.?

Vitamins or supplements? _____

Prescription Medications? _____

Has your child ever been hospitalized? If yes, please explain:

Has your child ever had surgery? _____

Circle any of the follow that your child has had in the past or currently has:

Ear infections	Allergies	Colic	Psoriasis	Bedwetting	Scoliosis
Chronic colds	Asthma	Eczema	Diabetes	Seizures	Fever
Visual Impairments	ADD/ADHD	Digestive Problems		Growing Pains	
Headaches	Back Aches	Chicken Pox	Rubella	Rubeola	Mumps
Measles	5 th Disease	Hand, Foot & Mouth Disease	Whooping Cough		

Other: _____

Has your child been immunized? Yes No

Any reactions to an immunization? _____

Other information that you would like us to know about your child that may help us understand their health history, habits, and complaints?

Authorization to treat a Minor:

I, _____ the undersigning parent/guardian having legal custody/guardianship of _____, a minor, do hereby authorize, request, and direct the doctors at Scatko Family Chiropractic PLLC to perform in good judgment any examination, chiropractic diagnosis, and treatment which is deemed necessary. I understand that I may ask questions at any time.

Privacy Verification (Please check if you AGREE to the statement)

I understand that I **may request** a copy of the Privacy Policy at any time and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

Permission to Contact

I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.

Payment Verification

I acknowledge that **full payment is due at the time of service** and I am responsible for any fees acquired from returned checks. I acknowledge that a **24-hour notice** is required to cancel or reschedule an appointment and that I may be charged \$20 if such notice is **not** given. I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

General Verification

To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

I acknowledge that I have had the opportunity to review the Notice of Privacy Practices on the date below on behalf of Scatko Family Chiropractic, PLLC.

Printed name of Patient _____

Printed name of Parent/Guardian _____

Signature of Parent/Guardian _____ Date _____

<i>Doctor Use Only:</i>	
Height: _____	Weight: _____