NEW PEDIATRIC PRACTICE MEMBER APPLICATION

Welcome to Pascal Chiropractic! We are so glad that you have taken the first steps in living a healthier life. Our mission is to help you achieve your health goals by optimizing your body's function and removing interferences to the body's nervous system.

Patient's Name _____ **Date** _____

Date of birth _____ **Parent's Names** _____

Address_____

Please complete this questionnaire. Your answers will help us determine if chiropractic care can help your child. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU.

What is the reason for the visit? _____

Other doctors seen for this condition:

_____

Treatment:

_____

Name of Pediatrician: _____ Date of last visit: _____

In order for us to better understand your child's current level of health, please check any of the following symptoms your child has or has had previously:

□ Headaches	□ Scoliosis	□ ADD/ADHD	□ PDD/Autism
□ Postural Imbalance	□ Seizures	□ Growing Pains	□ Car Accident
□ Asthma	□ Colic	□ Digestive Problems	□ Bed Wetting
□ Allergies	□ Sinus Problems	□ Frequent Colds	□ Ear Infection

□ Other: _____

List child's current medications (prescription or over-the-counter):_____

_____

Known Allergies and Reactions:

_____

_____

Number of doses of Antibiotics your child has taken:

During the past 6 months: _____ Total during his/her lifetime: _____

List Reasons:

_____

Number of doses of Prescription medications taken:

During the past 6 months: _____ Total during his/her lifetime: _____

List Medications:

_____

Immunization History

Yes	No	Date		Yes	No	Date	
□	□	_____	Hep B	□	□	_____	Polio shots
□	□	_____	DPT	□	□	_____	PCV7 (pneumococcal)
□	□	_____	Hib (influenza)	□	□	_____	MMR (combo or indiv, explain)
□	□	_____	Polio by mouth	□	□	_____	Varicella (chickenpox)

Others: _____

Prenatal History:

Adopted? □ No □ Yes

Complications during pregnancy? □ No □ Yes Please List:

_____

Medications/drugs/caffeine during pregnancy? □ No □ Yes Please List:

_____

Cigarette/Alcohol use during pregnancy? □ No □ Yes Please List:

_____

Location of Birth: □ Hospital □ Birthing Center □ Home

Birth Intervention (please check all that apply):

□ Mother Induced □ Mother Medicated □ C-Section

□ Forceps □ Vacuum

□ Baby given medication after delivery: _____

Complications during delivery? □ No □ Yes Please List: _____

Birth Weight: _____ Birth Length: _____ APGAR Scores: _____

Genetic disorders or disabilities? □ No □ Yes Please List:

_____

Jaundice? □ No □ Yes Infection? □ No □ Yes Transfusion? □ No □ Yes

Birth Defects? □ No □ Yes Breathing Problems? □ No □ Yes

Feeding & Diaper History:

Breast Fed? □ No □ Yes How Long? _____

Formula Fed? □ No □ Yes How Long? _____

If currently nursing, how often do they eat? _____

Introduced solids at _____ months. Introduced cow's milk at _____ months.

Food allergies or intolerances? □ No □ Yes Please List:

_____

In 24 hours, how many soiled/wet diapers does the child produce?

_____

Does the child strain/cry heavily when passing stool? □ No □ Yes

If weaned: what does the child's diet consist of?

_____

Childhood Diseases:

□ Chicken Pox Age: _____ □ Rubeola Age: _____ □ Whooping Cough Age: _____

□ Rubella Age: _____ □ Mumps Age: _____ □ Other: _____ Age: _____

Developmental History:

At what age was your child able to:

Respond to sound: _____ Crawl: _____

Respond to visual stimuli: _____ Stand Alone: _____

Hold head up: _____ Walk Alone: _____

Sit: _____

Trauma History:

Has your child even been involved in a car accident? □ No □ Yes Describe:_____

Have the child had any significant traumas or falls: □ No □ Yes Describe: _____

Any prior surgery? □ No □ Yes When? _____

Why? _____

Sleep:

On average, how much does the child sleep per 24 hours?

_____

How long does the child sleep overnight?

_____

Any naps during the day?

_____

Education and Social History:

Please explain any problems or concerns you have about our child in any of the following areas:

Appearance/Weight/ Height:

_____

Behavior:

_____

Friends:

_____

Grades/Learning ability:

_____

How many hours per day does your child watch TV or play video games? _____

Get exercise? _____

Have you noticed any of the following?

Angry Behavior? □ No □ Yes

Depression? □ No □ Yes

Changes in appearance? □ No □ Yes

Changes in attitude? □ No □ Yes

Skipping School? □ No □ Yes

Changes in friendships? □ No □ Yes

Withdrawal from friends or family? □ No □ Yes

Signs of drugs in the house? □ No □ Yes

Dr. Pascal does not treat medical conditions. His care is designed to help remove the barriers to normal body functions and help restore your body's own ability to be healthy and symptom free. If Dr. Pascal finds that they will be able to help you would you want to receive care? □ No □ Yes

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand that it is my responsibility to inform this office of any changes in my child's health.

I hereby authorize Dr. Pascal to examine me as he deems appropriate. I understand that the examination may exacerbate my condition. I understand that I am responsible for all of the bills that I incur at this office. Dr. Pascal will not be held responsible for any pre-existing medically diagnosed conditions, disease or for any medical diagnosis.

Guardian's Signature_____ Date_____