Hammond-Henry Hospital
Medical Group

Chiropractic New Patient

(Pediatric: Newborn – 10y)

Patient Name: _____ Date of Birth: _____ Age: _____

Allergies: _____

Referred by: _____ Primary Physician: _____

Previous Chiropractic Care? ☐ No ☐ Yes If yes, Name/Location: _____

Please answer the questions below to the best of your ability

1. What is the reason for today's visit? _____
2. When did symptom(s) begin? _____
3. Any history of accidents, serious injuries, other trauma? _____
4. Significant illnesses or hospitalizations? _____
5. Immunization status: ☐ Current ☐ Delayed ☐ None
6. Describe exercise routine/activity level: _____
7. Describe sleep patterns: _____
8. Describe temperament & social interactions: _____
9. Does anyone in the household smoke? ☐ Yes ☐ No

Pregnancy & Delivery Details (Newborn - 2 Years Only)

Place of Birth: _____
Name of Midwife or Obstetrician: _____
Birth Weight: _____ Birth Length: _____ Age of mother at baby's birth: _____
Infant's gestational age: ☐ Full Term ☐ Pre-Term (# of Weeks _____) ☐ Post-Term
Type of Delivery: ☐ Natural ☐ C-Section
Apgar scores (if known): _____
Initial feeding: ☐ Breastfed ☐ Bottle If bottle, was breastfeeding attempted? ☐ Yes ☐ No
Currently breastfeeding? ☐ Yes ☐ No Difficulty latching? ☐ Yes ☐ No
Currently eating solids? ☐ Yes ☐ No If yes, specify below
☐ Fruits ☐ Vegetables ☐ Meats ☐ Grains ☐ Dairy ☐ Nuts/Seeds
Immunization status: ☐ Current ☐ Delayed ☐ None
Did mother take any supplements or herbal remedies during pregnancy? ☐ Yes ☐ No
If yes, specify: _____
Did mother use cigarettes, alcohol, recreational drugs or prescription medications during pregnancy? ☐ Yes ☐ No
If yes, specify: _____
Describe mother's physical activity during pregnancy: _____
Describe mother's diet & nutrition during pregnancy/breastfeeding: _____
Were there complications during pregnancy? (diabetes, high BP, infections, preterm labor) ☐ Yes ☐ No
If yes, specify: _____
What was baby's presentation at 38 weeks: _____ At birth: _____
Were there any postpartum complications with mother and/or baby? ☐ Yes ☐ No
If yes, specify: _____

Pediatric Details (Ages 3 -10 years Only)

Describe patient's birth history (natural, C-section, forceps, epidural, Pitocin, length of labor, etc.) _____
_____
Initial feeding: ☐ Breastfed How long: _____ ☐ Formula fed How long: _____
Describe current diet & eating habits: _____
_____

Past Medical History

1. Have you been treated for any health conditions in the last year? ☐ No ☐ Yes

   If yes, describe: _____

2. Date of last physical exam (approximate is fine): _____ Doctor: _____

3. List any recent x-rays, MRI, or CT scans

Test	Approximate Date	Performed Where?

4. Describe history of major surgeries: _____

_____

5. Please indicate any condition(s) that you, or someone in your immediate family (parent or sibling) have been diagnosed with.

Condition	Relation (self, mom, dad, sibling, children)	Condition	Relation (self, mom, dad, sibling, children)
Musculoskeletal Disorder		Cancer	
Connective Tissue Disorder		Respiratory Issues	
Blood Clots		Osteoporosis/Osteopenia	
High Blood Pressure		Skin Conditions	
Low Blood Pressure		GI/GU	
High Cholesterol		Other: _____	

6. Please list all prescribed and over the counter medications and supplements you are currently taking.

Medication/Supplement Name	Dose	Frequency

Circle anything the patient has experienced in the last month:

WEIGHT	HEENT (continued)	GI (continued)	NEURO
Weight Changes	Ear Drainage	Vomiting	Seizures
ORAL HEALTH	Sore Throat	Vomiting Blood	Weakness
Dry Mouth	Mouth Breathing	Jaundice	Headaches
Mouth Pain	Snoring	Abdominal Pain	Numbness
Tooth Pain	Apnea	Colic	Slurred Speech
Swelling	White tongue patches	Appetite Change	**PUBERTAL**
Cavities	Nosebleeds	Fecal Blood	Menstrual Problems
SKIN	**CARDIAC**	**GU**	Pregnancy
Rash	Fatigue	Urinary Frequency	Sexual Activity
Swollen lymph node	Heart Murmurs	Pain with Urination	**ALLERGY**
Lumps	Exercise Intolerance	Blood in Urine	Hives
Bruising/Bleeding	Chest Pain	Abdominal Pain	Hay Fever
Pigment changes	Palpitations	Infections	Allergies
HEENT	**RESPIRATORY**	**MUSKULOSKELETAL**	Asthma
Headache	Wheezing	Joint Pain	Eczema
Concussions	Chronic Cough	Joint Swelling	Drug Reactions
Abnormal Head Shape	Productive Cough	Scoliosis	**PSYCHIATRIC**
Eye redness	Coughing up Blood	Muscle Aches	Difficulty Sleeping
Eye drainage	TB Exposure	Weakness	Behavior Changes
Vision Problems	**GI**	Injuries	Personality Changes
Hearing Problems	Diarrhea	Gait Changes	Hyperactivity
Ear Infections	Constipation	Delayed Milestones	

Other: _____

_____