BACK IN BALANCE wellness center
Phone: 207.947.8077 Fax: 207.947.3721
16 Penn Plaza • Suite 22 • Bangor, ME 04401
www.backinbalancechiro.com

PEDIATRIC: AGES 0-10

NEW PATIENT FORM

Today's Date (MM/DD/YYYY)

We comply with all federal privacy standards – all information you supply remains confidential.

Patient Number *(Office Use Only)*

Whom may we thank for referring you? ○ PCP ○ Yellow Pages ○ Internet ○ T.V. ○ Hospital ○ Radio ○ Event ○ Family/Friend

Child's Full Name | Age

Social Security Number | Birth Date *(MM/DD/YYYY)* | Gender ○ Male ○ Female | Race

Address | Home Phone | Preferred Language

City | State/Province | Zip/Postal Code | Ethnicity

Parent's Full Name | Birth Date *(MM/DD/YYYY)* | Parent's Cell Phone | Parent's Email

Parent's Full Name | Birth Date *(MM/DD/YYYY)* | Parent's Cell Phone | Parent's Email

Who is the emergency contact? ○ Mother ○ Father ○ Other *(Please Explain)*

Primary Care Provider's Name | Primary Care Provider's Phone Number | Last Visit *(MM/DD/YYYY)*

Purpose of Last Visit

Who is responsible for payment? ○ Mother ○ Father ○ Other *(Please Explain)*

Insured's Full Name | Insurance Carrier

Insured's Social Security Number | Insured's Birth Date *(MM/DD/YYYY)* | Policy Number

Insured's Employer | Group Number

Insured's Employer Address | *Secondary Insurance?* ○ *Yes* ○ *No*

City | *Secondary Insurance Carrier*

State/Province | Zip/Postal Code | *Secondary Insurance Policy Number*

Employer's Phone | *Secondary Insurance Group Number*

Who carries this policy? ○ Parent ○ Other

Do you have a pre-tax healthcare account? ○ HRA ○ HSA ○ FSA ○ POP ○ *N/A*

CONFIDENTIAL HEALTH INFORMATION

1. The symptom(s) that have prompted you to seek care today include - Please list in order of priority:

_____

2. And are the result of *(darken circle)*:
- ○ An accident or injury: ○ Auto ○ Other _____
- ○ A worsening long-term problem
- ○ An interest in: ○ Wellness ○ Other _____

3. Onset - *When did your child first notice the current symptoms?*

_____

4. Intensity - *How extreme are your child's current* ***symptoms****?*

○—○—○—○—○—○

Absent Mild Moderate Agonizing

5. Duration and Timing - *When did it start and how often does your child feel it?*

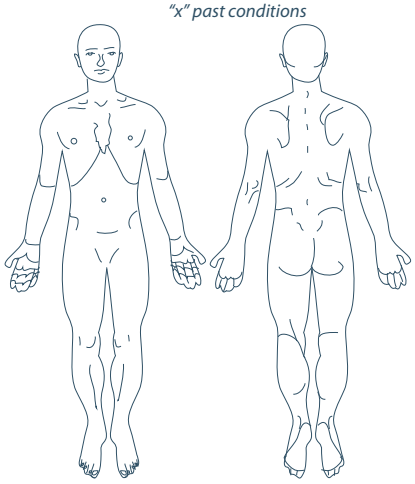
○ Comes and goes ○ Constant

How Often? _____

6. Quality of symptoms
What does it feel like?

- ○ Numbness
- ○ Tingling
- ○ Stiffness
- ○ Dull
- ○ Aching
- ○ Cramps
- ○ Nagging
- ○ Sharp
- ○ Burning
- ○ Shooting
- ○ Throbbing
- ○ Stabbing
- ○ Other _____

7. Location - *Where does it hurt? Circle the area(s)*
"0" current conditions
"x" past conditions



8. Radiation - *Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel.*

_____

9. Aggravating or relieving factors
What makes it better or worse, such as time of day, movements, certain activities, etc.
What tends to worsen the problem? _____
What tends to lessen the problem? _____

10. Prior interventions
What have you done to relieve your child's symptoms?

- ○ Prescription medication
- ○ Over-the-counter drugs
- ○ Homeopathic remedies
- ○ Physical therapy
- ○ Surgery
- ○ Occupational Therapy *(O.T.)*
- ○ Acupuncture
- ○ Chiropractic
- ○ Massage
- ○ Ice
- ○ Heat
- ○ Other _____

11. What else should we know about your child's condition? _____

_____

12. Review of Systems - *Darken the circle of any condition that your child suffered from in the* ***PAST*** *or* ***PRESENT***

Past	Present		Past	Present		Past	Present	
○	○	Asthma	○	○	Frequent Diarrhea	○	○	Failure to Thrive / Slow Weight Gain
○	○	Respiratory Tract Infections	○	○	Constipation	○	○	Slow or Absent Reflexes
○	○	Sinus Problems	○	○	Flatulence	○	○	Asymmetrical Crawling or Gait
○	○	Ear Infections	○	○	Headaches/Migraines	○	○	Weight Challenges
○	○	Tonsillitis	○	○	Neck Pain	○	○	Bed Wetting
○	○	Strep Throat	○	○	Torticollis / Head Tilt	○	○	Sleep Problems
○	○	Frequent Colds / Croup	○	○	Trouble Feeding on One Side	○	○	Night Terrors
○	○	Recurrent Fevers	○	○	Back Pain	○	○	Tip Toe Walking
○	○	Eczema	○	○	Growing Pains	○	○	Sensory Processing Issues
○	○	Rashes	○	○	Scoliosis	○	○	Seizures
○	○	Allergies	○	○	Red, Swollen, Painful Joint	○	○	Tremors / Shaking
○	○	Food Sensitivities	○	○	Colic	○	○	ADD / ADHD
○	○	Digestive Problems	○	○	Frequent Crying Spells	○	○	Autism / PPD

PRENATAL

13. Prenatal Profile

○ Adopted ○ Prenatal history unknown ○ Birth history unknown

Complications during pregnancy: ○ No ○ Yes *(brief description):* _____

Ultrasounds during pregnancy: ○ No ○ Yes *(brief description):* _____

Medications during pregnancy: ○ No ○ Yes *(If yes, which ones and how often including OTC):*

_____

Exposure to drugs, alcohol, cigarettes, or second hand smoke during pregnancy: ○ No ○ Yes

(brief description) _____

Patient Name _____

Patient Number *(Office Use Only)* _____

Consultation Notes

Doctor's Signature _____

Date _____

14. Birth Experience

BIRTH

Location of Birth: ○ Home ○ Hospital ○ Birthing Center ○ Other: _____

Birth Attendants: ○ Doula ○ Midwife ○ GP ○ OB ○ Other: _____

Medications during labor / delivery *(including IV antibiotics)*: ○ No ○ Yes: _____

Was Pitocin used to induce / speed up labor? ○ No ○ Yes _____

Were the membranes ruptured by a medical professional? ○ No ○ Yes

Was the baby at anytime during your pregnancy in a constrained position? ○ No ○ Yes ○ Unsure

If yes, please describe: ○ Breech ○ Transverse ○ Face / Brow presentation

Type of delivery? ○ Vaginal ○ C-section? *If C-section, was it* **planned** *or* **emergency***? Circle one*

If it was ***vaginal,*** was the baby presented: ○ Head ○ Face ○ Breech

Were any of the following interventions used? ○ Forceps ○ Vacuum Extraction ○ Other _____

Were there any complications during delivery? ○ No ○ Yes *If yes, please specify:* _____

_____

How long was the labor from the first regular contractions to the birth? _____ hours

How long was the second stage *(the pushing phase)* of the labor? _____ hours

Was vitamin K administered after birth? ○ No ○ Yes

Was the baby born with any purple markings / bruising on their face or head? ○ No ○ Yes

Any concerns about misshapen head at birth? ○ No ○ Yes

After birth, was cord clamping delayed for at least 3 minutes? ○ No ○ Yes

15. Post Natal and Infant History

INFANT

How many weeks gestation was the baby at birth? _____ Weight _____ Length _____

If known, APGAR scores at: 1 minute: _____ /10 5 minutes: _____ /10

Was the baby ever administered to the NICU? ○ No ○ Yes *If yes, for how long and why:* _____

_____

Was any medication given to your child at birth? ○ No ○ Yes ○ Unsure

If yes, what medication and why? _____

Was your child exclusively breastfed? ○ No ○ Yes Months: _____

Was your child breastfed + formula fed? ○ No ○ Yes Months: _____

Did your child show any sensitivities to formula (reflux, eczema, arching back)? ○ No ○ Yes

What age did you introduce solid foods to your child? _____ months

Did you introduce cereal or grains within your child's first year? ○ No ○ Yes

Did your child spend a lot of time in any baby devices (bouncy seats, swings, bumbos, car seats, etc)?

○ No ○ Yes *Which ones?* _____

16. Physical Trauma

Has your child ever fallen from any high places? ○ No ○ Yes _____

Has your child ever been involved in a motor vehicle accident? ○ No ○ Yes _____

Has your child been seen on an emergency basis? ○ No ○ Yes _____

Has your child broken any bones? ○ No ○ Yes _____

Has your child had any previous hospitalizations? ○ No ○ Yes _____

Has your child had any previous surgeries? ○ No ○ Yes _____

Does your child use a tablet, computer, or video game? ○ *Never* ○ *Rarely* ○ *Daily* ○ *Several hrs/day*

Does your child watch TV? ○ *Never* ○ *Rarely* ○ *Daily* ○ *Several hrs/day*

Does your child exercise? ○ *No* ○ *Daily* ○ *Weekly* ○ *Seasonally*

Does your child play contact sports? ○ *No* ○ *Daily* ○ *Weekly* ○ *Seasonally*

Does your child sleep on their… ○ *Back* ○ *Belly* ○ *Sides (both, right, left)*

Does your child carry a back pack? ○ No ○ Yes

Does it weigh less than 15% of their body weight? ○ No ○ Yes

Do they wear their back pack on 2 shoulders? ○ No ○ Yes

Does your child show excessive or uneven shoe wearing out? ○ No ○ Yes

Does your child wear custom orthotics? ○ No ○ Yes *For what purpose?* _____

Patient Name

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Consultation Notes

Doctor's Signature

Date

17. Chemical Stressors

Have you chosen to vaccinate your child? ○ No ○ Yes ○ *on a delayed schedule* ○ *on schedule*

Reason for vaccination: ○ *Personal research* ○ *Didn't know I had a choice* ○ *It was recommended*

Reaction(s) to vaccination: ○ *None* ○ *Fever* ○ *Diarrhea* ○ *Rash* ○ *Welt at injection site* ○ *Fatigue* ○ *Seizures* ○ *Prolonged Cry* ○ *Developmental Regression* ○ *Other* _____

Does your child receive annual flu shots? ○ No ○ Yes *(personal research)* ○ Yes *(MD recommended)*

Has your child been exposed to antibiotics? ○ No ○ Yes *(personal research)* ○ Yes *(MD recommended)*

If yes, how many doses in past 6 months? _____ *Reason:* _____

Has your child been exposed to medications, including over the counter medicine? ○ No ○ Yes

If yes, which ones? _____

If yes, how many doses in past 6 months? _____ *Reason:* _____

18. Nutrition Profile

How many glasses of water/day does your child have?	○ 0	○ 1-3	○ 4-6	○ 7-9	○ 10+
How many glasses of cow's milk/day?	○ 0	○ 1-3	○ 4-6	○ 7-9	○ 10+
How many glasses of juice/day?	○ 0	○ 1-3	○ 4-6	○ 7-9	○ 10+
How many glasses of soda/day?	○ 0	○ 1-3	○ 4-6	○ 7-9	○ 10+

Does your child eat gluten? ○ No ○ Yes ○ Trying to eliminate

Does your child eat dairy? ○ No ○ Yes ○ Trying to eliminate

Any food/drink allergies or sensitivities? ○ No ○ Yes _____

Is your child exposed to second hand smoke? ○ No ○ Yes _____

Does your child take a probiotic daily? ○ No ○ Yes _____ CFU's/day

Does your child take a vitamin D3 daily? ○ No ○ Yes _____ IU's/day

Does your child take Omega 3 Fish Oils daily? ○ No ○ Yes _____ mg/day

Other supplements or homeopathics? _____

Does your child take a multi-vitamin daily? ○ No ○ Yes *Brand* _____

19. Goals and Consent

Do you feel your child is developmentally appropriate for their age?

	Yes	*No*	
Intellectually	○	○	_____
Emotionally:	○	○	_____
Physically:	○	○	_____

What is your primary goal for your child at our clinic? _____

20. In addition to the main reason for your visit today, what additional health goals do you have?

_____

21. Would you like to learn more about: ○ *chiropractic* ○ *acupuncture* ○ *massage therapy* ○ *nutrition* ○ *exercise*

I, _____ *(parent/legal guardian)* give my permission to Back in Balance Wellness Center and the providers within to perform the necessary evaluation, diagnostic tests and to render the recommended health services, thereafter to _____ *(print name of minor)* as they deem appropriate.

I _____ *(parent/legal guardian)* understand and agree that all services rendered to my child at this office are my responsibility, regardless of insurance coverage. I have read and signed the practice's financial policy and understand that I am ultimately personally responsible for payment.

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

_____ *Parent/Legal Guardian's Signature*

_____ *Date (MM/DD/YYYY)*

Patient Name _____

Patient Number *(Office Use Only)* _____

Consultation Notes

Doctor's Signature _____

Date _____