Pediatric New Patient Application

MOTIVITY
CHIROPRACTIC

Today's Date: _____/_____/_____ Appointment Reminders: ☐ Text ☐ Email

How did you hear about us? _____

CHILD'S INFORMATION

Legal Name: _____ Preferred Name: _____

DOB: _____/_____/_____ Age: _____ Weight: _____ ☐ Male ☐ Female

Address: _____

City: _____ State: _____ Zip: _____

PARENT'S INFORMATION

Name: _____ Phone: _____ E-mail: _____

Employer: _____ Occupation: _____

Marital Status: _____ SSN: _____ Driver's License: _____

Payment Method: ☐ Cash ☐ Credit Card ☐ Personal Check

INSURANCE INFO

Do you have insurance? ☐ Yes ☐ No Is your child covered by this insurance? ☐ Yes ☐ No

Primary insurance: _____ Policy #: _____

Policy holder's name: _____ Policy holder's DOB: _____

Covered dependents: _____

Secondary insurance: _____ Policy #: _____

Policy holder's name: _____ Policy holder's DOB: _____

Covered dependents: _____

MOTHER'S PREGNANCY & LABOR

During Pregnancy: ☐ Drugs ☐ Medicine ☐ Vaccinations ☐ Tobacco ☐ Alcohol

Please explain: _____

Any illness during your pregnancy? _____

How was your delivery? (select all that apply)

☐ Labor medically induced ☐ Labor was Dr. assisted ☐ C-section delivery ☐ Forceps

☐ Vacuum extraction ☐ Dr. pulled or twisted baby ☐ Premature delivery

Please explain: _____

Did your baby have colic? ☐ Yes ☐ No Feeding problems? ☐ Yes ☐ No

Nursing? ☐ Yes ☐ No When weaned? _____

PURPOSE OF VISIT

Describe the purpose of this visit: _____

Is the purpose of this appointment related to: ☐ Sports ☐ Auto Accident ☐ Fall ☐ Home Injury ☐ Other: _____

When did this condition begin? _____

Has this condition: ☐ Gotten Worse ☐ Stayed Constant ☐ Come & Gone

Does this condition interfere with: ☐ Sleep ☐ Daily Routine ☐ Other: _____

Has this condition occurred before? ☐ Yes ☐ No Please explain: _____

Have you seen other doctors for this condition? ☐ Yes ☐ No Doctor's Name(s): _____

Type of Treatment: _____ Results: _____

Has your child been to a Chiropractor before? ☐ Yes ☐ No Approximate date of last visit: _____

Reason for visit: _____ Doctor's Name: _____

CHILD'S HEALTH HISTORY

Please check each of the diseases or conditions that the child has now or has had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan, and possibility of being accepted for care.

☐ Allergies	☐ Breathing problems	☐ Ear problems	☐ Irritability
☐ Asthma	☐ Colic	☐ Frequent colds	☐ Skin problems
☐ Attention problems	☐ Constipation	☐ Headaches	☐ Tubes in ears
☐ Bedwetting	☐ Digestive problems	☐ Hyperactivity	☐ Vision problems
☐ Alternate crawl patterns	☐ Sudden developmental regression	☐ Picky eater	☐ Other: _____

Have you chosen to vaccinate your child? ☐ Yes ☐ No Followed standard schedule? ☐ Yes ☐ No

If vaccinated, which ones has your child received? _____

Did your child have any reactions to vaccinations? ☐ Yes ☐ No

If yes, please describe _____

Has your child ever:

- ☐ Taken antibiotics
- ☐ Been hospitalized
- ☐ Had a severe fall
- ☐ Been in a car accident
- ☐ Had surgery
- ☐ Had difficulty interacting with others
- ☐ Delayed in reaching a development milestone

Is your child accident-prone? ☐ Yes ☐ No

Is your child taking any medication(s)? ☐ Yes ☐ No If yes, which medications? _____

Have you or anyone else noticed that your child is nervous, twitches, shakes, or exhibits rocking behavior? ☐ Yes ☐ No

Please explain: _____

What changes (if any) in your child's health or behavior would you like accomplished?

_____

CONSENT

Person responsible for account (billing, appointment, and treatment information): _____

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my (or minor patient's) medical status. I authorize staff to perform necessary services that I (or minor patient) may need during diagnosis and treatment with my informed consent.

I authorize payment to be made directly to Motivity Chiropractic for all benefits which may be payable under a healthcare plan or from any other collateral sources. I understand I am responsible for payment, including copayment and/or deductible, for services at the time they are rendered.

_____ _____/ _____/ _____

Signature of Patient (Parent or Legal Guardian) **Date**