THE DRUGLESS DOCTORS
Chiropractic, Family Health, and Wellness

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Pediatric Registration Form

Child's Name: _____ Date:_____ File Number:_____
Parent Names: _____ Sibling's Names & Ages:_____
Child's Age: _____ Birth date: _____ Sex: M F Address:_____
Home Phone:_____ Other Numbers:_____
Family doctor's name and address: _____

Who may we thank for referring you?_____
Has your child ever received chiropractic care? **Yes / No** If Yes, Previous Chiropractor?:_____
The date of last visit:_____ The reason for the last visit:_____
Other professionals seen for this condition: _____
Results with that treatment? _____
Recent tests done (list date beside): □ Bloodwork _____ □ Urine _____ □ X-Rays _____
Other: explain _____
Please circle the purpose for your child's visit:
crisis management early detection of problems prevention wellness
maximizing normal growth and development other:_____

PRESENT HEALTH CONCERNS

Primary Concern:_____
Secondary Concerns: _____
When did this problem begin?_____
Is this problem: occasional frequent constant intermittent
Does problem radiate (or travel to other areas)? **Yes / No** If Yes, where? _____
What makes this worse?_____ What makes this better?_____
Is the problem worse during a certain time of the day? **Yes / No** If Yes, when?_____
Does this interfere with the child's sleep? **Yes / No** Eating? **Yes / No** Daily routine? **Yes / No**
Is this becoming worse? **Yes / No**
Often seemingly unrelated symptoms can manifest as other health concerns. Please circle all that apply

headaches	chest pressure	weight loss	dizziness	breast pain
weight gain	irritability	frequent colds	dental problems	fatigue
sinus congestion	fevers	depression	sore throats	heart palpitations
loss of balance	ear pain/infections	numbness in feet	loss of concentration	asthma
numbness in hand(s)	fainting	cold sweats	weakness	ears buzzing
bronchitis	heartburn	poor coordination	pneumonia	muscle cramps
vision changes	difficulty breathing	upper back pain	loss of memory	shortness of breath
neck pain	loss of smell	allergies	low back pain	loss of taste
constipation	radiating pain	light sensitivity	diarrhea	sleeping problems
face flushed	urinary problems	numbness in leg(s)	reduced mobility	bloating/gas
stiffness	☐ Other: _____			

BIRTH HISTORY

What was the child's gestational age at birth? ____ weeks. Birth weight _____lbs ____oz. Birth length _____ inches
Was your child's birth: at home / in a birthing center / hospital / other:_____
Was the birth considered: medical / midwife Duration of birth: _____ hours
Was child born: cephalic (head first) / breech (feet first)
Were there any complications? **Yes / No** If Yes, please explain
_____
Assistances used during delivery: Forceps / Vacuum extraction / C-section / Episiotomy
Was labor: spontaneous / induced Were medications or epidurals given to the mother during birth? **Yes / No**
APGAR score: at Birth _____/10 After 5 minutes___/10 Any other important birth info? **Yes / No**

GROWTH & DEVELOPMENT

Was the infant alert and responsive within 12 hours of delivery? **Yes / No**
If no, please explain _____
At what age did the child::
Respond to sound _____ Follow an object _____ Hold up head _____ Vocalize _____
Sit alone _____ Teethe _____ Crawl _____ Walk _____
Does your child sleep: front / back / side How many hours per day? _____
Do you consider the child's sleeping pattern normal? **Yes / No** If no, please explain _____

FAMILY HEALTH HISTORY

Please note any health problems (ie: cancer, hereditary conditions, diabetes, heart disease) that are present in:
Mothers family: _____
Fathers family: _____
Siblings: _____

PHYSICAL STRESSORS

Since problems that chiropractors look for and detect can be related to many types of stressors, the following information is also very important to us.
Any traumas to the mother during pregnancy? (ie. falls, accidents, etc.) **Yes / No** If yes, please explain _____
_____
Any evidence of birth trauma to the infant?
bruising odd shaped head stuck in birth canal
cord around neck respiratory depression fast or excessively long birth
Any falls from couches, beds, change tables, etc? **Yes / No** If yes, please explain _____
Any traumas resulting in bruises, cuts, stitches or fractures? **Yes / No** If yes, please explain _____
Any hospitalizations or surgeries? **Yes / No** If yes, please explain _____
Any sports played? _____
Is a school backpack used? **Yes / No** Is it: heavy / light

CHEMICAL STRESSORS

Was this child breast-fed? **Yes / No** If yes, how long: _____
Formula introduced at what age: _____ Which formula? _____
Introduced cow's milk at what age: _____ Began solid foods at what age: ____ Types of solid foods:_____
Food/Juice intolerance? **Yes / No** Type: _____
Is your child on or have taken any medications? **Yes / No** _____
During the mother's pregnancy:
Did the mother smoke? **Yes / No** How much? _____ Drink alcohol? **Yes / No** How much? _____
Any illnesses during the pregnancy? **Yes / No** If yes, describe:_____
Any supplements taken during pregnancy **Yes / No** If yes, describe:_____
Any drugs taken during pregnancy? **Yes / No** If yes, describe: _____
Any ultrasounds? **Yes / No** How many:_____ Reasons for being done:_____
Any invasive procedures during pregnancy (ie amniocentesis, Chorionic villi sampling, etc.)? **Yes / No**
If yes, please explain _____
Any pets at home? **Yes / No** _____ Any smokers in the home? **Yes / No**
Any antibiotics given? **Yes / No** If yes, reason: _____
Is the diet organic? **Yes / No** Do you use 'green products' in your home for cleaning? **Yes / No**
How often do they receive processed foods, white sugar, gluten (flour), dairy in their diet?
Never / On weekends / A few times per week / Daily / Nearly each meal / On special occasions
Are you aware of the impact of nutrition on children's behavior*?* **Yes / No**
Would you like information on nutrition for your child*?* **Yes / No**

PSYCHOSOCIAL STRESSORS

Any difficulties with lactation? **Yes / No** _____ Any problems with bonding? **Yes / No** _____
Any behavioral problems? **Yes / No** _____ Any inattention? **Yes / No** _____

Any hyperactivity or restlessness? **Yes / No** _____ Any compulsiveness? **Yes / No** _____
Any difficulties at daycare or school? **Yes / No** _____
Any challenges with learning deficiencies? **Yes / No** _____
Any night terrors, sleep walking, difficulty sleeping? **Yes / No** _____
Any prolonged temper tantrums or separation anxiety? **Yes / No** _____
Is the child in day care **Yes / No** _____ Age of child when began daycare? _____
Is there a nanny or regular sitter during the day if both parents work **Yes / No** _____
Is the child home schooled? **Yes / No** _____by Whom? _____
Average number of hrs of electronics per week? TV _____ Video Games _____ Texting/Smart Phone _____
Do you feel that your child's social and emotional development is normal for their age? **Yes / No**

INFORMED CONSENT FOR CARE

A practice member, in coming to the chiropractic doctor, gives the doctor permission and authority to care for the practice member in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the practice member susceptible to injury. The doctor, of course, will not give any treatment or care if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the practice member to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a practice member by a physician at The Drugless Doctors, I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Missed Appointments:

There is a possible cancellation fee charged for appointments that are not canceled in advance. Visits missed while on a care plan must be made up within the time frame of the care plan.

Guarantee of Results:

The purpose of chiropractic care is to improve the health and function of the spine and nervous system. It is not to treat disease, suppress symptoms, medically diagnose, perform surgery or prescribe medications. If you desire any of these we will gladly refer you for those services. Practice member acknowledges that any and all questions regarding benefits, risks and alternatives have been answered to their satisfaction.

Women/Girls Only:

To the best of my knowledge I **am / am NOT** pregnant and (**give my permission / don't give permission**) to x-ray me for diagnostic interpretation. Pregnancy Complications: _____

Communications:

In the event that we would need to communicate your healthcare information, to whom may we do so?
Name(s): _____ No one: _____
Please indicate if our office can leave a message on your voicemail regarding your personal health information. Y [ ] N [ ]
Please indicate if we can text office updates in the case of weather alerts or special office announcements. Y [ ] N [ ]
Please indicate if we can send email information to the provided email address through unsecure means. Y [ ] N [ ]

Release of Medical Information:

I certify that I (or my dependent) assign directly to The Drugless Doctors all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize this office to release any information requested by my insurance company to document my claim for benefits. I understand that I am personally responsible for full payment of all charges for my treatment. Services are payable at the time rendered. X-rays remain the property of this clinic and will only be released to another physician after receiving a proper release authorization request from said physician. X-ray will not be released directly to practice members.

Determination of Treatment:

I understand and agree that the doctors of The Drugless Doctors have the right to decline or accept me as a practice member at any time before treatment begins. Taking a history and conducting an examination are a part of the process of information gathering, so that the doctor can determine whether to admit me as a practice member or not.

Minor Consent:

I am authorized to and do consent to all treatments performed by the doctors and staff of The Drugless Doctors and rendered to the minor practice member named on this registration form.

Acknowledgement

I have read and fully understand the above statements. I have received and/or reviewed the notice of privacy practices (HIPAA-Posted at northcoastchiro.net/new-practice member-info) and understand that I have the opportunity to discuss my right to privacy upon request.

Print Name: _____ Signature: _____ Date: _____
Dr. Signature: _____ Robert DeMaria/Anthony DeMaria/Casen DeMaria Date: _____