SCOTT S. SARDONICUS, DC

215 BROWNS RIDGE RD; OSSIPEE NH 03864

Today's Date: _____

PEDIATRIC NEW PATIENT HISTORY

Patient Name: _____ Parent/Guardian's Name: _____

Birth Date: _____ Sex: _____ Parent/Guardian's Name: _____

Mailing Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

e-mail: _____ How did you hear about us? _____

REASON FOR VISIT

Are you here for: ☐ a wellness checkup ☐ a specific concern

Current health concern: _____

_____

_____

WHEN and HOW did it begin? _____

_____

Are there times, activities, and/or treatments that make it BETTER? _____

_____

WORSE? _____

Other treatments tried and effects: _____

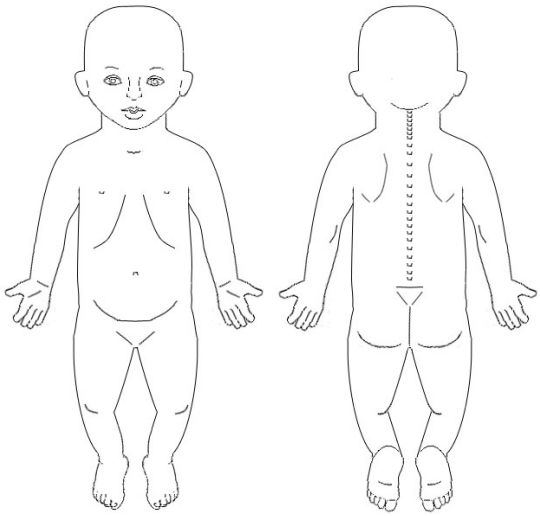
_____

Is your child currently seeing another health care provider? ☐ No ☐ Yes: If yes, give name & phone # and for what reason _____

_____

_____

Please indicate, in red, areas of pain or discomfort.



Has your child ever been under chiropractic care in the past? ☐ No ☐ Yes

Date of last visit:_____ for what reason:_____

About how many adjustments were given? _____ Previous chiropractor's name & phone #: _____

_____

Has your child experienced any of the following:

☐ Vision problems	☐ Asthma	☐ Irritability	☐ Digestive problems
☐ Pink eye / conjunctivitis	☐ Sleeping difficulty	☐ Skin problems	☐ Hyperactivity
☐ Constipation	☐ Attention problems	☐ Frequent colds	☐ Allergies _____
☐ Headaches	☐ Tubes in ears	☐ Bedwetting	_____
☐ Ear problems	☐ Colic	☐ Breathing problems	_____

Other health concerns (include frequency, duration and severity): _____

_____

_____

_____

_____

PRENATAL HISTORY

Name of Obstetrician / Midwife / Other: _____

During pregnancy, did the mother:

Take any medications: ☐ No ☐ Yes: explain: _____

Use cigarettes / alcohol: ☐ No ☐ Yes: _____

Experience any illness: ☐ No ☐ Yes: _____

Have an ultrasound: ☐ No ☐ Yes: _____

Were there any complications during the pregnancy? ☐ No ☐ Yes: _____

Location of birth: ☐ Hospital ☐ Home ☐ Birthing Center ☐ _____

Birth presentation: ☐ Cephalic (head first) ☐ Breech ☐ Occiput Posterior (facing forward)

Did the person assisting the delivery twist or pull the baby during the delivery? ☐ No ☐ Yes _____

What was the mother's position during labor? ☐ Back ☐ Side ☐ Sitting ☐ Standing ☐ Other _____

Were there any complications during birth? ☐ No ☐ Yes: _____

Labor length: _____ ☐ Chemically induced ☐ Doctor-assisted ☐ Premature _____

Birth Intervention: ☐ Forceps ☐ Vacuum Extraction ☐ Cesarean Section: Emergency or Planned?

Were any drugs administered during the labor process? (IV or epidural) ☐ No ☐ Yes _____

Was the child breast-fed soon after birth? ☐ Yes ☐ No Any difficulties? _____

Was your child subjected to any of the following: ☐ Silver nitrate eye drops ☐ Incubation (duration _____) ☐ Vitamin K injection ☐ Hepatitis injection ☐ Separation from mother (duration _____)

Genetic disorders or disabilities? ☐ No ☐ Yes: _____

List any **family** health problems that may affect this child's health: _____

Birth weight: _____ Birth height: _____ APGAR scores: _____, _____

FEEDING HISTORY

Breast fed: ☐ No ☐ Yes: how long: _____

Formula fed: ☐ No ☐ Yes: how long: _____ Type: _____

Introduced to solids at: _____ months, Cow's milk at _____ months

CURRENT EATING HABITS

What is a typical: Breakfast for your child? _____

Lunch: _____

Dinner: _____

Snack (include frequency): _____

Please circle Yes or No as the following applies to your child. Indicate how much and how often.

Drink water	Y N	_____	Fresh fruit	Y N	_____	White sugar	Y N	_____
Whole grains	Y N	_____	Fruit juice	Y N	_____	Soda	Y N	_____
Fresh vegetables	Y N	_____	Sweets	Y N	_____	Junk food	Y N	_____
Green vegetables	Y N	_____	Dairy products	Y N	_____			

Does your child's diet include any sources of Omega-3 Essential Fatty Acids? ☐ No ☐ Yes: frequency: _____

DEVELOPMENTAL HISTORY

At what age was your child able to do the following: (normally expected ages are in parentheses). If you don't know, put a question mark.

Hold head up (4 weeks): _____
Follow an object (3 mos): _____
Respond to sound (3 mos): _____
Respond to visual stimuli (3 mos): _____
Sit up (6 mos): _____
Stand alone (10 mos): _____
Walk alone (10-12 mos): _____
Vocalize (2 mos): _____

CRAWLING HISTORY: Did your child crawl? Did it look balanced with opposite arm and leg moving at the same time? At what age? (normally 7-10 mos)

_____

Other developmental concerns (attach a separate sheet of paper if necessary): _____

_____

_____

Do you feel that your child's social and emotional development is normal for their age? (please explain) _____

_____

Is your child accident-prone? ☐ Yes ☐ No

Average number of hours your child watches television, plays on the computer or plays electronic games each week, if any: _____

TRAUMA HISTORY

According to the National Safety Council, approx 50% of children fall head first from a high place during their first year of life (ie a bed, changing table, down stairs, etc) was this the case with your child? ☐ No ☐ Yes: _____

Has your child ever been in an auto accident? ☐ No ☐ Yes: date, explain: _____

_____

Is/has your child been involved in any high impact or contact type sports (ie soccer, football, gymnastics, baseball, cheerleading, martial arts, etc): ☐ No ☐ Yes: list: _____

Is a school backpack used? (heavy or light) _____

Other traumas not described above: _____

Has your child ever undergone surgery? ☐ No ☐ Yes: _____

Circumcision? ☐ No ☐ Yes: _____

Is your child ☐ currently taking *or* ☐ taken in the past any medications? ☐ No ☐ Yes: _____

Vaccination history: ☐ Full recommended schedule ☐ None ☐ Other (specify): _____

Please describe any reactions to the vaccine(s): _____

_____

What changes in your child's health would you like to see? _____

_____

Is now a good time to commit to cultivating these changes? ☐ Yes ☐ No _____

Who is on your child's health care team? (massage, nutrition, acupuncture etc) _____

_____

Family Constellation: Please list names and ages of all members of your household: _____

_____

Authorization for Care of Minor: I hereby authorize this clinic and its doctor(s) to administer care as they deem necessary to my child.

_____

Signed Witness Date