NEW PATIENT INFORMATION | PEDIATRIC

KUPERUS FAMILY CHIROPRACTIC

Please Print & Complete or Email Electronically Completed Form to: **KuperusFrontDesk@gmail.com**

Child's Name: Date Of Birth:

Nickname: Gender At Birth: Male Female Other

Pronouns: He She They Race:

Ethnicity: Preferred Language:

Home Address:

City: Zip:

PARENT 1	**PARENT 2**
Name:	Name:
Home Phone:	Home Phone:
Mobile Phone:	Mobile Phone:
Work Number:	Work Number:
Preferred Contact: Home Work Cell	Preferred Contact: Home Work Cell

Emergency Contact Name & Phone:
(Other Than Parent)

Emergency Contact Relation To Child:

How were you referred to our office?

Primary Care Physician Name & Phone:

INSURANCE INFORMATION

Please indicate any and all insurance coverage that may be applicable in this case.
Please bring proof of insurance coverage to your child's appointment.

Primary Insurance: Secondary Insurance:

Yes No I grant Dr. Kuperus permission to speak to my child's other health care providers regarding my child's health.

Yes No I grant Dr. Kuperus permission to take photos of my child for medical documentation.

Yes No I grant Dr. Kuperus permission to take photos of my child for research and publication. The parent will be notified before any publication occurs.

Parent Signature Date

LIST ANY DIAGNOSES YOUR CHILD HAS RECEIVED:

CURRENT CONDITION

Major complaints/goals in seeking Chiropractic care:

DIGESTIVE HEALTH

Loose stool/diarrhea Yes No

Mucus in stool Yes No

Chronic constipation Yes No

Reflux Yes No

Smelly gas Yes No

Stomach pains Yes No

Undigested food in stool Yes No

Extremely large stool Yes No

Is your child potty trained (both bowel and bladder) Yes No

ANTIBIOTIC HISTORY

Approximately how many antibiotics has your child been on in their lifetime?

Main reason for antibiotic use:

Has your child ever been treated for a yeast infection? Yes No

DIET

If possible please bring a diet log of at least 2-3 days to initial consultation

Gluten Free Casein Free Other Diet:

What are your child's favorite foods?

Are they a picky eater?

What do they typically drink?

How many glasses of water a day?

TRAUMA/SURGERIES

Date of last physical:

Has your child ever been in any accidents, auto, fall down stairs, fall from ladder, or other significant trauma? Yes No

When/Describe:

Does your child play sports?

List all surgeries and date:

List all significant illness (mumps, measles, TB, pneumonia, etc.)

Please list all prescription and over-the-counter medications:

Name of medication	Dosage	Frequency	For what condition	How long have you been taking it?	Prescribing MD

Please list all supplements/vitamins/herbs your child is taking:

Does your child have medication allergies? (Please list medications and reaction)

Is your child up to date on vaccines? Yes No

Has your child ever had a vaccine reaction? Yes No

If yes, please explain:

List all therapies your child is currently receiving and therapist (OT, Speech, PT, Hippotherapy, Aqua, etc.):

Check all that apply:

Colic	Head banging	Growing pains	Eczema
Abnormal head shape	Acid Reflux	Hypotonic	Teeth grinding
Diaper Rash	Headaches	Food allergies	Back/Neck Pain
Torticollis	Staring spells	Clumsy	Chronic Ear Infection
Stimming	Restless sleeping	Stomach aches	
Congenital Hip Dysplasia	Verbal delay	Bed wetting	
Toe walking	Vision issues	Asthma	

Please list the approximate age when your child achieved the following milestones:

First introduced to solids: Sat on own:

Crawled: Describe abnormal crawl patterns:

Walked: Age when said first word:

FAMILY HISTORY	Child	Father side	Mother side	Sibling
Kidney Disease				
Thyroid Disease				
Cancer				
Arthritis				
Osteoporosis				
Scoliosis				
Depression				
Neurological Disorder				
Allergies				
Asthma				
Schizophrenia				
Genetic Disorder				
OCD/Anxiety				
Celiac Disease				
Other:				

BIRTH HISTORY

Length of Pregnancy weeks Weight and length at birth:

Were there any complications during pregnancy?

Seizures High Blood Pressure Diabetes Pre-term labor

Other (please describe)

Describe delivery (hrs in labor, c-section/vaginal delivery, use of Pitocin, forceps or vacuum)

Breastfed? (Y/N, how long, if NO, why not and list any difficulty with breastfeeding)

INFANTS

Does your Infant have a preferred head position? Yes No

Does your Infant cry during a diaper change? Yes No

Does your infant hate belly time? Yes No

Does your infant arch his/her neck backwards? Yes No

Use the following space to list ANYTHING else you think is important and want the Doctor to know: