Name:_____ D.O.B._____ Acct #:_____

PEDIATRIC NEW PATIENT APPLICATION

PATIENT INFORMATION

Child's Nickname: _____ Today's Date: _____

Reason for the visit: _____

Gender: M / F Date of Birth: _____ Age: _____ Child's SS # _____

Home Address:_____ City / State / Zip: _____

Who may we thank for referring you? _____

Pediatrician: _____ City _____ Phone _____

According to the National Safety Council, approximately 50% of infants fall head first from a high place (bed, changing table, etc.) during their first year of life. Has this happened to your child? Yes / No

Falls/Accidents? _____

Learned to walk _____ months Was a walker used? Yes / No

Child's prior doctor of chiropractic? _____ / City? _____ How did he adjust? _____

Was your prior chiropractic doctor present during delivery? Yes / No Date of last visit with prior chiropractor: _____

Other doctors who have treated this problem: _____

Surgery? _____

Medications? _____

Have you noticed any abnormality with the way your child walks or runs? (Ex: limps, high hip, feet turn in or out)?

_____

Other concerns you have? _____

FAMILY INFORMATION

Mother's Name _____ Cell _____

Father's Name _____ Cell _____

Parent's Marital Status: ____Married ____Single ____Divorced ____Widowed

Names and Ages of Other Children in Family: _____

Father/Mother/Brother/Sister with similar problem? Yes / No Who? _____

Predominant Language Used at Home: ____English ____Spanish ____Other: _____

Race: American Indian or Alaska native / Asian / Black or African American / White or Caucasian / Native Hawaiian or Pacific Islander / Other / I Decline to Answer

PAYMENT INFORMATION

How do you wish to cover today's visit? ____Cash ____Check ____ Debit/Credit Card

Do you have health (crisis care) insurance that covers chiropractic? Yes / No (Please give us a copy of your insurance card)

Insured's: date of birth _____ SS# _____ Employer _____

CONSENT TO TREAT

Being the parent or legal guardian of this child, I hereby authorize this office and its doctors to examine and administer care to my son / daughter named _____ as the examining / treating doctor deems necessary.

I understand and agree that I am personally responsible for payment of all fees charged by this office for such care.

☐ I choose to decline receipt of my clinical summary after every visit (These are often blank as a result of the nature and frequency of a chiropractic care plan).

Parent's Name: _____ Signature: _____ Date _____

Destiny CHIROPRACTIC

Name:_____ D.O.B._____ Acct #:_____

PREGNANCY HISTORY

Today's Date _____

Gender: M F Date of birth _____ Age _____

Mother's Name _____ How many children do you have? _____

What was the term of your pregnancy? _____ weeks

DURING YOUR PREGNANCY, DID YOU HAVE ANY OF THE FOLLOWING:

	YES	NO	
Falls?	❑	❑	_____
Motor Vehicle Accidents?	❑	❑	_____
Near-miss MVA?	❑	❑	_____
High B/P?	❑	❑	_____
Diabetes?	❑	❑	_____
Anemia?	❑	❑	_____
Morning sickness?	❑	❑	_____
Indigestion?	❑	❑	_____
Seizures?	❑	❑	_____
Swollen ankles?	❑	❑	_____
Thyroid problems?	❑	❑	_____
Heart problems?	❑	❑	_____
Back pain?	❑	❑	_____
Abnormal bleeding?	❑	❑	_____
Were you hospitalized?	❑	❑	_____
Any other Illnesses?	❑	❑	_____

DURING YOUR PREGNANCY, DID YOU USE ANY OF THE FOLLOWING:

	YES	NO	
Tobacco?	❑	❑	_____
Alcohol?	❑	❑	_____
Non-prescribed drugs?	❑	❑	Drug _____ Reason _____
Prescription medication?	❑	❑	Medication _____ Reason _____
Over-the-counter meds?	❑	❑	Medication _____ Reason _____

Name:_____ D.O.B._____ Acct #:_____

BIRTH HISTORY

Today's Date _____

Gender: M F Date of Birth _____ Age _____

LABOR AND DELIVERY

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

How long was the 2nd stage (the pushing phase) of the labor? _____ hours

	Yes	No	
Full term	❑	❑	If not, what week? _____
Hospital birth	❑	❑	_____
Home birth	❑	❑	_____
Midwife assisted	❑	❑	_____
Was it a difficult labor	❑	❑	Describe any complications and when they occurred _____
			_____
			_____
Vaginal Delivery	❑	❑	_____
Planned C-section	❑	❑	_____
Emergency C-section	❑	❑	_____
Was Birth Induced (Pitocin)	❑	❑	at what week of pregnancy? _____
Forceps delivery	❑	❑	_____
Vacuum extraction	❑	❑	_____
Anesthesia (epidural/other)	❑	❑	_____
Fetal distress	❑	❑	_____
Meconium staining	❑	❑	_____
Head presentation	❑	❑	_____
Face presentation	❑	❑	_____
Breech presentation	❑	❑	_____

BABY'S CONDITION IMMEDIATELY AFTER BIRTH:

Apgar Scores: At 1 minute _____/ 10 At 5 minutes _____/ 10

Baby's Crying Baby Cried Immediately After Birth _____

Cried Strongly _____ Weak Cry _____ Did Not Cry for _____ minutes

Baby's Color Pink all over _____ Blue face _____ Blue Hands/feet _____

Baby's activity Arms and legs actively moving _____ Floppy baby _____

Intensive Care Was required _____ Days in Neonatal Intensive Care Unit _____

Medication given at birth? _____ Vaccines administered _____

Birth weight _____ lbs / kgs Birth length _____ ins / cms Baby came home at age _____

Name:_____ D.O.B._____ Acct #:_____

Pediatric New Patient Application
DEVELOPMENTAL MILESTONES

Date _____

Gender M F DOB _____ Age _____

Please indicate the most complex skill that your child can perform in each section.

In each section, the tasks are arranged in order of increasing developmental age.

Gross Motor Skills

- ❑ able to hold head up from the table momentarily
- ❑ head and shoulder can be supported by the forearms
- ❑ infant can be pulled up into a sitting position by the hands
- ❑ sits unsupported in the upright position
- ❑ head and shoulders can be supported by the arms
- ❑ rolls from prone to supine position
- ❑ crawls
- ❑ stands holding onto furniture
- ❑ walks with someone holding onto one hand
- ❑ walks unassisted
- ❑ runs
- ❑ negotiates stairs placing 2 feet on each step
- ❑ climbs stairs using one foot on each step
- ❑ walks down stairs with one foot on each step
- ❑ hops on one foot

Social Skills

- ❑ smiles
- ❑ reaches for familiar objects
- ❑ plays with hands
- ❑ plays with feet
- ❑ clearly shows joy and pleasure
- ❑ feeds self with fingers
- ❑ plays peek-a-boo
- ❑ understands yes and no

Fine motor skills

- ❑ Primitive grasp reflex present
- ❑ holds and shakes a rattle placed in the hand
- ❑ grasps objects independently
- ❑ moves an object from one hand to the other
- ❑ self-feeding, can hold and eat a cookie
- ❑ checks objects by placing them in the mouth
- ❑ picks up object with thumb and index finger
- ❑ turns 2 to 3 pages of a book at a time
- ❑ turns pages of a book one at a time
- ❑ builds a tower containing at least 5 blocks
- ❑ builds a tower containing at least 10 blocks

Communication skills

- ❑ makes cooing sounds
- ❑ laughs
- ❑ uses one syllable words such as "da"
- ❑ uses 2 syllable words such as "dada"
- ❑ uses 2 to 3 word vocabulary
- ❑ uses 2 to 3 word phrases

Adaptive Skills

- ❑ feeds from a cup unassisted
- ❑ holds own bottle
- ❑ feeds self with utensils
- ❑ able to identify and match some colors
- ❑ copies a circle
- ❑ copies a cross

Name:_____ D.O.B._____ Acct #:_____

SCHOOL-AGE CHILD HISTORY

6 years and Older

Today's Date _____

Gender: M F Date of Birth _____ Age ____

Reason for Today's Visit _____

When did this problem first occur? _____

Yes No

❑ ❑ Have you ever had this problem before? _____

Yes No

❑ ❑ Have you previously been treated for this problem? Doctor's name _____

Yes No

❑ ❑ Have you previously been to a chiropractor? When? _____

ABOUT YOUR HEALTH

In the past year have you had any of the following

Yes No

❑ ❑ Back or neck pain? _____

Yes No

❑ ❑ Pains in the legs or arms? _____

Yes No

❑ ❑ Headaches? _____

Yes No

❑ ❑ Asthma? _____

Yes No

❑ ❑ Allergies? _____

Yes No

❑ ❑ Earaches? _____

Yes No

❑ ❑ Falls from a bicycle, skateboard, scooter, rollerblades or similar? _____

Yes No

❑ ❑ Do you ever have a problem with bedwetting? _____

Yes No

❑ ❑ Have you ever been in a motor vehicle accident? _____

Yes No

❑ ❑ Have you ever had any broken bones? _____

Yes No

❑ ❑ Have you ever had any surgeries? _____

Yes No

❑ ❑ Are you at present taking any medications? _____

Yes No

❑ ❑ Do you have any other health problems? _____

Name:_____ D.O.B._____ Acct #:_____

SCHOOL-AGE CHILD HISTORY

6 years and Older

ABOUT YOUR LIFESTYLE

What grade are you in at school? _____

How do you carry your school books? _____

How heavy is your school book bag? _____

What sports do you play? _____

What hobbies do you have? _____

How many hours each day do you watch TV? _____

How many hours each day do you spend using a computer? _____

How often do you play video games? _____

On average, how many hours sleep do you get each night? _____

Are there any smokers in your family? _____

Do you feel stressed out? _____

Do you have trouble reading the board in class? _____

Do you ever have blurred vision? _____

Do you wear glasses or contact lenses? _____

Do you sometimes get headaches when you read? _____

ABOUT YOUR DIET

What do you usually eat for Breakfast? _____

_____

What do you usually eat for Lunch? _____

_____

What do you usually eat for Dinner? _____

_____

What snacks do you have after school? _____

What is your favorite food? _____

How much water do you drink each day? _____

How many sodas or colas do you drink each day? _____

How often do you eat fast food items? _____

Name:_____ D.O.B._____ Acct #:_____

PATIENT APPLICATION FOR CARE 3/5

Systems Review

It is important to read the following before filling out this form.

Any and all physical events that our body goes through leaves obvious and in most cases not so obvious findings. Therefore, it is important you take time and thoughtfully (as well as honestly) answer all the following questions. Even the ones you believe we have already verbally asked you.

1. **Review of Systems**

(Chiropractic focuses on the integrity of your nervous system which controls and regulates your entire body.

Please circle any condition that you have had or currently have.

Musculoskeletal:
osteoporosis
arthritis
scoliosis
neck trouble
mid back trouble
Low back trouble
hip disorders
knee injuries
foot/ankle
shoulder/elbow/wrist
TMJ
poor posture

Neurological:
anxiety
depression
headache
dizziness
tingling
numbness

Cardiovascular:
high blood pressure
low blood pressure
poor circulation
angina
excessive bruising
high cholesterol

Respiratory:
Asthma
Apnea
Emphysema
hay fever
shortness of breath
pneumonia

Digestive:
anorexia/bulimia
ulceri
food sensitivities
heartburn
constipation/diarrhea

Sensory:
blurred vision
ringing in ears
hearing loss
chronic ear infections
loss of smell
loss of taste

Skin:
skin cancer
psoriasis
eczema
acne
hair loss
rash
tattoo(s)
body piercing(s)

Endocrine :
thyroid issues
immune disorders
hypoglycemia
frequent infections
swollen glands
low energy

Genitourinary:
kidney stones
infertility
bedwetting
prostate issues
erectile dysfunction
PMS symptoms

Constitutional :
fainting
low libido
poor appetite
fatigue
sudden weakness
weight loss/gain

Name:_____ D.O.B._____ Acct #:_____

PATIENT APPLICATION FOR CARE 4/5

2. Illnesses

AIDS	HIV positive
Alcoholism	malaria
Allergies	measles
arteriosclerosis	Multiple Sclerosis
cancer	mumps
chicken pox	polio
diabetes	Rheumatic Fever
epilepsy	STD
glaucoma	stroke
goiter	tuberculosis
gout	Typhoid Fever
heart disease	ulcer
hepatitis	other _____

3. Surgeries

bypass surgery
cancer
cosmetic surgery
elective surgery _____
eye surgery
hysterectomy
pacemaker
spine _____
tonsilectomy
vasectomy
other _____

4. Treatments

acupuncture
acupressure
antibiotics
birth control pills
blood transfusions
chemotherapy
chiropractic care
dialysis
herbs/homeopathy
inhaler
massage therapy
physical therapy

5. Injuries (have you ever had)

had a fractured/broken bone
had a spine or nerve disorder
been knocked unconscious
been injured in an accident
used a crutch or other support
used neck or back bracing

6. Social History

(Tell Dr. Bonner about your health, hobbies and stress levels)

alcohol use	○ daily	○ weekly	How much? _____	Prayer/meditation?	○ yes	○ no
coffee use	○ daily	○ weekly	How much? _____	Job pressure/stress?	○ yes	○ no
tobacco use	○ daily	○ weekly	How much? _____	financial peace?	○ yes	○ no
exercising	○ daily	○ weekly	How much? _____	Vaccinated?	○ yes	○ no
pain relievers	○ daily	○ weekly	How much_____	mercury fillings?	○ yes	○ no
soft drinks	○ daily	○ weekly	How much? _____	recreational drugs?	○ yes	○ no
water intake	○ daily	○ weekly	How much? _____			

Hobbies: _____times/week _____ hours/time _____

7. Family History

Age (if living)	State of health		Illnesses	Age at death	Cause of death		
	Good	Poor			Natural	Illness	Injury
Mother _____	○	○	_____	_____	○	○	○
Father _____	○	○	_____	_____	○	○	○
Sister 1 _____	○	○	_____	_____	○	○	○
Sister 2 _____	○	○	_____	_____	○	○	○
Brother 1 _____	○	○	_____	_____	○	○	○
Brother 2 _____	○	○	_____	_____	○	○	○
_____	○	○	_____	_____	○	○	○

_____ _____ _____ _____

Patient signature Date Doctor signature Date

Name:_____ D.O.B._____ Acct #:_____

AUTHORIZATION - The process of determining suitability for Chiropractic Services involves answering fully and truthfully all questions presented to you either written or spoken regarding your past and present health status. If warranted, a physical examination will be performed that can include but is not limited to vitals measurement, systems evaluation, orthopedic tests and maneuvers (tests that move and stress parts of the body), neurological test (tests using sharp or dull instruments, smells or sounds, gently tapping) as well as physical touching. These test and maneuvers will help the Chiropractor determine what may be causing your complaints and if Chiropractic can help. Occasionally some temporary soreness and/or stiffness may occur due to the examination; less frequently aggravation of presenting symptoms or initiation of new symptoms. By signing below, you have authorized the performance of a consultation and examination.

ACKNOWLEDGEMENTS - We are very concerned with protecting your personal health information. There may be times our office may need to contact you regarding office matters. By signing below, you have authorized this office to contact you for office related matters and thank you notices for referrals using your first name in the following manner: phone-work-home or mobile, e-mail and regular mail to include sealed envelopes and postcards. Messages may be left on an answering device/voicemail, or with the person answering your phone-home-work-mobile. Also, in accordance with the Health Insurance Portability and Accountability act of 1996 (HIPAA), updated September 23, 2013, this office is obliging to supply you with a copy of the office privacy policies and procedures upon request. This document outlines the use and limitations of the disclosure of your personal health information and your rights as a patient.

Also, I acknowledge Chiropractic is a separate and distinct practice from traditional medicine.

Also, I acknowledge that Dr. Bonner will deliver care that, in her professional judgment, can best help me in the restoration of my health. I also acknowledge that the chiropractic care offered in this practice is based on acceptable standards of care designed to reduce or correct vertebral subluxation.

Also, I realize that an x-ray exam may be hazardous to an unborn child and I certify that to the best of my knowledge I am NOT pregnant. Date of last menstrual period ___/___/_____

Also, I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

I ACKNOWLEDGE THAT I HAVE BEEN OFFERED A COPY OF:
NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION.

_____ _____
Patient Name Printed Date

_____ _____
Patient Signature Authorized Provider Rep.

_____ _____
Personal Representative Printed Personal Rep. Signature

_____
Description of personal representative's authority to act for the patient