MESA
CHIROPRACTIC
REHAB & WELLNESS

Mesa Chiropractic Rehab & Wellness Patient Application

WELCOME TO OUR OFFICE

(Please print in **BLUE** or **BLACK** ink. If anything does not apply to you please put **N/A** on the line.)

PEDIATRIC FORM (ages 0-12)

Section 1: Patient Information Today's Date:____/____/____

Name (first, middle, last):____

Preferred Name:____________________ ▢ Male ▢ Female Date of Birth___/___/___ Age:______

Address:________________________________ City:_______________ State:____ Zip:_________

Patient's SSN (last 4):____________________ Email:____

Parent(s)/Guardian(s) Name_______________________________SSN (last 4):__________________

Phone Number: Cell (____)_____________ Home (____)_____________ Work (____)____________

Emergency Contact:_________________ Relationship:______________ Phone: (____)____________

Who may we thank for referring you to our office? ____

Section 2: Current Health Condition

What health condition(s) brings your child to our office? Please explain__________________________

____

If your child is experiencing pain or discomfort please identify where and for how long_______________

____

When did the symptoms appear?_____________________ Has it ever occurred before? ▢ Yes ▢ No

Was it due to an accident? ▢ Yes ▢ No If yes, please explain________________________________

Are the symptoms? ▢ Occasional (1-33%) ▢ Intermittent (34-66%) ▢ Frequent (67-99%) ▢ Constant (100%)

Is this condition getting ▢ Better ▢ Worse or is it staying the ▢ Same?

Does anything make the problem better? ▢ Yes ▢ No If yes, what_____________________________

Does anything make the problem worse? ▢ Yes ▢ No If yes, what_____________________________

Have you seen any other doctors for this? ▢ Yes ▢ No If yes, please list doctor's name and treatment if any____

Section 3: Medications	Vitamins/Supplements	Allergies
__________________________	__________________________	__________________________
__________________________	__________________________	__________________________
__________________________	__________________________	__________________________

Parent/Guardian's Signature: _______________________________________ Date: ____/____/____

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Section 4: Medical History

Using the codes below, please fill in **EVERY** blank with the applicable letter.

C = **C**urrent Health Condition **P =** **P**ast Health Condition **N =** **N**ever had this Health Condition

___ADHD/ADD	___Cancer	___Hernia	___Psychiatric Care
___Allergies	___Chronic Colds	___Kidney Disease	___Reflux
___Anemia	___Colic	___Migraines	___RSV
___Anxiety/Depression	___Constipation	___Mononucleosis	___Scoliosis
___Asthma	___Diarrhea	___Muscle Pain	___Shortness of Breath
___Autism/Spectrum Dis.	___Digestive Problems	___Nausea/Vomiting	___Sore Throat
___Autoimmune Dis.	___Dizziness/Vertigo	___Neck Pain	___Skin Problems
___Back Pain	___Ear Infections	___Nosebleed	___Sleeping Problems
___Bed Wetting	___Epilepsy/Seizures	___Numbness/Tingling	___Toe Walking
___Behavior Problems	___Fatigue	___Pneumonia	___Torticollis
___Bleeding Disorder	___Headaches	___Poor Appetite	___Tumors/Growths
___Broken Bones	___Hearing Problems	___Poor Motor Skills	___Ulcers
___Bronchitis	___Heart Problems	___Poor Posture	___Weight Problems

Please list any other complaints / conditions your child currently has or has had in the past_____________

____

Please list all broken bones/injuries/major falls/surgeries/hospitalizations your child has had and the date they occurred____

____

Is there anything else the doctor should know? ▢ Yes ▢ No If yes, please describe_________________

____

Section 5: Family History

Does anyone in your family suffer from the same condition(s) or other chronic illnesses? ▢ Yes ▢ No

If yes, whom and what condition(s)____

____

Section 6: Chiropractic History

Has your child ever seen a Chiropractor before? ▢ Yes ▢ No Date of most recent visit_____________

For what reason was he/she seen?_____________________________ Was he/she helped? ▢ Yes ▢ No

Parent/Guardian's Signature: ____ Date: ____/____/____

Section 7: Prenatal History

Child's birth was ▢ At home ▢ At a birthing center ▢ At a hospital

Name of obstetrician / midwife / family physician:____

Child's birth was ▢ Natural vaginal (no medications/interventions) ▢ Vaginal with intervention(s) ▢ C-section

If intervention(s), what? ▢ Induction ▢ Pain medication ▢ Epidural ▢ Episiotomy

▢ Vacuum extraction ▢ Forceps ▢ Other___________________________

If C-section, was it ▢ Scheduled or ▢ Emergency?

Please list reasons for any interventions/complications____

____

Ultrasounds during pregnancy? ▢ Yes ▢ No If yes, how many and what was the medical reason?___

____

Medications during pregnancy? ▢ Yes ▢ No If yes, what?____________________________________

Cigarette use during pregnancy? ▢ Yes ▢ No Alcohol use during pregnancy? ▢ Yes ▢ No

Birth weight_________ Birth length_________ APGAR at birth________ APGAR after 5 min.________

Section 8: Growth and Development

Name of Pediatrician:____Date of last visit____/____/____

Was your child alert and responsive within 12 hours of delivery? ▢ Yes ▢ No

If no, please explain____

At what age did your child: Respond to sound_______ Follow an object_______ Hold head up________

Teethe________ Crawl________ Walk________ Vocalize________

Is/was your child breastfed? ▢ Yes ▢ No If yes, how long?_________

Is/was your child fed formula? ▢ Yes ▢ No If yes, what type?__________________________________

Introduction of cow's milk at age________ Began solid foods at age________

Please list any food(s)/juice(s) intolerance____

Does your child eat well? ▢ Yes ▢ No Have regular bowel/bladder movements? ▢ Yes ▢ No

Has your child received any vaccinations? ▢ Yes ▢ No If yes, which ones and list any reaction(s)___

____

Has your child received any antibiotics? ▢ Yes ▢ No If yes, how many times and for what reason?__

____

Parent/Guardian's Signature: ____ Date: ____/____/____

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Section 9: Goals For Your Child's Care

People see a chiropractor for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their body. Your doctor will weigh your child's needs and your desires when recommending his/her care program. Please check the type of care des so that we may be guided by your wishes whenever possible. Thank you.

- ▢ I want the Doctor to select the type of care appropriate for my child's condition(s).
- ▢ Relief Care: Symptomatic relief of pain or discomfort
- ▢ Corrective Care: Correcting and relieving the cause of the problem as well as the symptom(s).
- ▢ Wellness Care: My child is healthy and I want to do whatever I can to keep him/her healthy.

Section 10: Our Commitment to You and Your Child

We are committed to giving your child the best care possible in our office. If there is ever anything you wish to talk to the doctor about whether it be a question, concern or how we may better help you or your child, please let one of us know. We are here to serve you and your child and we thank you for the opportunity.

Section 11: Preferred Contact Number and Time

Please indicate your preferred contact number and time of day. Thank you.

Preferred Contact Number:____

Preferred Time:____

Parent/Guardian's Signature: ____ Date: ____/____/____