Maple Chiropractic Pediatric Application

Dr. Nicole Granert
1000 S. Maple Ave., Glen Rock, NJ 07452

Patient's Name:_____ **Today's Date**:_____

Date of Birth: _____ Age:_____ Sex: M F

Name of Parents/Gardians:_____

Address:_____ City:_____ State:_____ Zip Code:_____

Phone (Home):_____ Parent(Cell): _____

Parent Email:_____

Primary Language: _____ Race: _____ Ethnicity: _____

Is the child living with: Mother Father Both

Current Height: _____ Current Weight: _____

Name of School: _____ Grade: _____

Who referred you to our office? _____

Reason you are seeking Chiropractic Care for your child? _____

Please list any health concerns: _____

Symptoms: (please circle any current problems)

Dizziness Diarrhea Broken Bones Sprain/Strain ADHD Backaches Headaches

Heart Conditions Constipation Chronic Ear Infections Frequent Colds Asthma Leg Pain

Neck Pain Arm Pain Blood Disorder Stomach Aches Muscle Pains Muscle Cramps Anemia

Poor Appetite Over Eating Rash Sinus Troubles Cough Wheezing Bed wetting

Difficulty Sleeping Behavior Trouble Focusing Difficulty Breast Feeding/latching

Please list any allergies: _____

Name of Pediatrician/Phone Number: _____

Is your child receiving or have they received in the past Physical Therapy, Occupational Therapy or Speech Therapy? If yes, please list name of provider: _____

Medications your child is taking: _____

Supplements your child is taking: _____

What sports/extracurricular activities does your child participate in?

_____

Has your child been involved in a motor vehicle accident? _____

List all hospitalizations and reason why: _____

Prenatal History

Where was your child born? _____

Was the birth natural or C-section? _____

Were there any complications with the birth or pregnancy? If yes, please state:

_____

Does your child have a genetic disorder? _____

Developmental History

Has your child been diagnosed with a below average or abnormal development for crawling, sitting, standing, walking, saying words, coordination of fine motor skills or any other developmental delays? If yes, please explain:

_____

_____

Please describe your child's sleep habits: _____

History of Childhood Disease

Chicken Pox Y/N Mumps Y/N Rubella Y/N Whooping Cough Y/N Meningitis Y/N

Measles Y/N Tuberculosis Y/N Others: _____

Is your child's vaccination Schedule current? If not, what vaccinations has your child NOT received?

_____

Patient Gardian Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____