New Patient Registration – Pediatrics
(Ages birth – 5 years)

Please note that all information is strictly confidential.

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. Here at this office we offer chiropractic and rehabilitative wellness care; this health information can be used for any and all of the above. If we believe that we cannot assist you with your health care needs, we will be more than happy to refer you to the appropriate health care professional. If you have any questions, please ask. Thank you.

First Name: _____ **Middle Initial:** _____

Last Name: _____

Date of Birth: ___/___/___ **Age:** _____ **Social Security #:** _____

Height: _____ **Weight:** _____

Gender: [ ] Male [ ] Female

Address: _____ **City/State/Zip:** _____

Home Phone: _____ **Cell Phone:** _____

We offer a complementary monthly Wellness eNewsletter for our patients.
Email Address: _____

How did you hear about us? _____

Insurance Information: If you haven't done so already, please *pre-verify* your benefits. We are not responsible for any misquote of said benefits. If we will be assisting you in billing your insurance, please fill out the following:

Name of Insurance Provider: _____

Name of Policy Holder (Primary Plan Holder): _____ DOB: _____

Policy Holder's Address & Phone Number: _____

Member ID Number: _____

Insurance Phone Number (back of card): _____

Parent/Guardian Signature: _____ Date: _____

SoundCare Chiropractic
4347 Roosevelt Way NE ● Seattle, WA 98105 ● Office: (206) 633-5556 ● Fax: (206) 633-5559

Pediatric Health History

Primary reason for contacting our office: _____

Any additional concerns? _____

Has your child ever been checked by a Doctor of Chiropractic? ❒Yes ❒No Whom? _____

Were x-rays taken? ❒Yes ❒No Who is your regular pediatrician? _____

Did you have an ultrasound with this pregnancy? _____Frequency _____

Place of birth ❒Hospital ❒Home ❒Birthing Center

Provider ❒Midwife ❒OB/GYN ❒Other

Type of Birth ❒Vaginal ❒C-Section Was anesthesia used? _____Type _____

Complications? _____ Full Term? _____ Birth Ht./Wt. _____

Was labor induced?_____

Birth Trauma

- Newborn trauma (medical procedures and tests _____
- Apgar scores at birth?_____
- Spontaneous respiration?_____
- Any complications or nursery stay?_____

Did you breast feed your child? ❒Yes ❒No

If yes, how long? _____

If child is currently on solid foods, how would you describe his/her appetite?_____

_____

Does your child consume artificial sweeteners? _____

How often does your child have a bowel movement? _____

Has your child reached all of the expected milestones for their age category? _____

_____

Are there any concerns? _____

According to the National Safety Council approx. 50% of infants have fallen onto their heads during their first years of life. Another study reveals 1/4 million children are injured in playgrounds annually.

Can you recall any such jolts, falls or traumas to your child? ❒Yes ❒No

Please Describe: _____

Any fractures or dislocations?_____

Which sports does your child play? Soccer/ Football /Gymnastics/ Karate/ Hockey/ Lacrosse/ Basketball/ Dance/ Wrestling/ Baseball/ Other_____

Other than the 5 hours per day spent sitting in the classroom, does your child spend additional prolonged time sitting? ❒Yes ❒No Is it in front of a computer or TV? ❒Yes ❒No

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Circle any of the following conditions your child has suffered from:

❒Colic ❒ Irregular Sleeping Patterns ❒Night Terrors ❒Seizures ❒Tantrums
❒ Ear Infections ❒Allergies ❒Asthma ❒Headaches ❒Poor Digestion
❒Repeated Infections or Colds ❒ Bed Wetting ❒Learning Disorders
❒Emotional Disorders ❒ADD or ADHD
❒Other_____

How would you rate your child's immune system? _____

Specific illnesses? _____

Is your child currently on any medications? (Please list) _____

_____

Has your child been treated with antibiotics? ❒Yes ❒No How many times?_____

Any surgeries?_____

How often has your child been treated with drugs and/or vaccinations? _____

_____

AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize **Dr. Ryan Smith/SoundCare Chiropractic,** to administer care as deemed necessary to my son/daughter.

Parent/Guardian _____Date_____

Signature _____Date_____

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