Oasis Chiropractic Center New Patient Form Ages 12 & Under

Today's Date: _____ Patient ID#_____
(Office Use only)

Child's Name: _____
(Patient Name)
Child's Nick Name: _____

Date of Birth: mm/dd/yyyy _____/_____/_____ Child's Age: _____

*Are you the: ❑Mom ❑Dad ❑Other: _____

Your Name: _____ Preferred Name: _____
(Parent or Guardian) Title: (check one) ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. ❑ Other

❑ **Single** ❑**Married** ❑ **Widowed** ❑**Separated** ❑ **Divorced** ❑**Domestic Partnership**

Cell Phone: _____ Home Phone: ❑n/a _____Work Phone: ❑n/a _____

Which do you prefer to receive calls at: ❑ Home ❑ Work ❑ Cell ❑ No Preference

Which do you prefer to receive appointment reminders? EMAIL❑ (please write below) or CELL PHONE TEXT❑

What is your mobile carrier's Name? AT&T❑ Sprint❑ Virgin Mobile❑ Verizon❑ T-Mobile❑ Metro PCS

Other❑ _____

E-mail address_____@_____
(Please print legibly)
Let's keep in touch: Please note that your information is *kept* strictly *confidential* and is ***not*** shared with any outside parties.
If Dr. Starkman needs to send you any information like (homecare, nutritional survey, stretches etc.) He'll send it to the email address you have provided ^^^^above, if you have chosen to receive email appointment reminders it will be sent to the email you have provided above. Please make sure it's legible.

Join others who love chiropractic, connect with patients who are also on their wellness journey, stay up to date with our specials and events.
Do you have *Facebook?* YES❑ NO❑ Can we friend request you for our **Oasis Chiropractic Center Page** ? YES❑ NO❑

How did you find out about Oasis: ❑ Internet /Google ❑ FaceBook ❑ Twitter ❑ Can't remember ❑ Pediatrician
❑ Prior Patient ❑ Health Fair/Educational Work Shop ❑ Office Staff ❑ Other _____

Primary **Address** of Child: _____City:_____ Zip Code:_____

Child's Current Weight_____ Current Length/Height _____Number of Siblings_____

Name of other
parents/guardians:_____

❑**Self**
Emergency Contact: (Name) _____ (Relationship) _____ (Phone number) _____

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DEVELOPMENTAL HISTORY

If you cannot remember or don't know please mark an X in the space provided for the answer.

During the following times your child's spine is most vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral Subluxation (spinal nerve interference).

At what age was your child able to: write age in space provided

Respond to Sound_____ Cross Crawl_____ Stand Alone_____ Hold Head Up_____ Sit Alone_____ Stand_____

Follow An Object With His/Her Eyes_____ Crawl_____ Walk Alone_____ Toilet trained_____

At what age did your child say the alphabet in order _____ At what age did your child begin to read _____

Did your child sleep with parents? ❑YES ❑NO When did this stop? _____

At What Age, If Ever, Did This Child Suffer From The Following Childhood Diseases?

Chickenpox_____ Mumps_____ Measles_____ Rubella_____ Rubeola_____ Whooping Cough_____

Has the Child Ever had or have any of the following:

☐ **Headache**	☐ **Orthopedic Problems**	☐ **Digestive Disorders**	☐ **Behavioral Problems**
☐ **Dizziness**	☐ **Neck Problems**	☐ **Poor Appetite**	☐ **ADD/ADHD**
☐ **Fainting**	☐ **Arm Problems**	☐ **Stomach Aches**	☐ **Ruptures/Hernia**
☐ **Seizures/Convulsions**	☐ **Leg Problems**	☐ **Reflux**	☐ **Muscle Pain**
☐ **Heart Trouble**	☐ **Joint Problems**	☐ **Constipation**	☐ **Growing Pains**
☐ **Earaches /Infections**	☐ **Backaches**	☐ **Diarrhea**	☐ **Allergies to:**_____
☐ **Sinus Trouble**	☐ **Poor Posture**	☐ **Diabetes**	☐ **Allergies to:**_____
☐ **Asthma**	☐ **Scoliosis**	☐ **Hypertension**	☐ **Allergies to:**_____
☐ **Colds/Flu**	☐ **Walking Trouble**	☐ **Anemia**	☐ **Emotional Stress**
☐ **Colic**	☐ **Broken Bones**	☐ **Bed Wetting**	☐ **ADD or ADHD (age diagnosed)** _____
☐ **Temper Tantrums**	☐ **Vision problems**	☐ **Hearing problems**	☐ **Autism**

What social behavior have you observed with your child? (check all that apply)

☐ **normal social interaction** ☐ **too close or clingy to family** ☐ **dominates others** ☐ **very shy** ☐ **too distant from family**

☐ **associates with acting-out peers** ☐ **dominates others** ☐ **few friends** ☐ **difficulty making friends** ☐ **isolates self**

Has your child ever repeated a grade ☐ **yes** ☐ **no** **When/Why?** _____

How would you rate your child's academic learning? ☐ **Below Average** ☐ **Average** ☐ **Above Average**

How would you describe your child's level of activity? ☐ **Overactive** ☐ **Average** ☐ **Underactive**

What extracurricular activities has your child been involved in? _____

_____

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e. a bed, changing table, down stairs, etc). Was this the case with your child? ☐ No ☐ Yes

Has This Child Ever Suffered The Following Spinal Traumas?

☐ **Fall in Baby Walker**	☐ **Fall from Bed or Couch**	☐ **Fall off Skateboard or Skates**
☐ **Fall from Crib**	☐ **Fall off Swing**	☐ **Fall off Bicycle**
☐ **Fall from Highchair**	☐ **Fall off Slide**	☐ **Fall down Stairs**
☐ **Fall from Changing Table**	☐ **Fall off Monkey Bars**	☐ **Other** _____

OASIS CHIROPRACTIC CENTER
DR. MYLES STARKMAN
799 BRICKELL PLAZA #803
MIAMI, FL 33131

DEVELOPMENTAL HISTORY (2)

Is / has your child been involved in any high impact or contact type sports (i.e. soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.)? ☐ No ☐ Yes

List: _____

Has This Child Ever Sustained Injuries In An Auto Accident? _____ If Yes, Please Explain: _____

Hospitalization/Surgeries _____

Medications _____

Family History of **health, mental health, drug or alcohol** _____

BIRTH INFORMATION

Third Trimester Presentation: (check box) ☐ **Vertex** ☐ **Breech** ☐ **Transverse** ☐ **Face/Brow**

Type of Birth: ☐ **Normal Vagina** ☐ **Forceps** ☐ **Suction Cap or Vacuum** ☐ **CESSARIAN -** ☐ **EMERGENCY or** ☐ **PLANNED?**

Location of birth: ☐ **HOSPITAL** ☐ **BIRTHING CENTER** ☐ **HOME**

Problems During Pregnancy _____

Problems During Labor/Delivery _____

Apgar Scores: _____ _____ Was There Presence at Birth of ☐ Jaundice (Yellow) ☐ Cyanosis (Blue)

Congenital Anomalies/Defects? ☐ Yes ☐ No If Yes, Please Explain _____

INFANT FEEDING

DID YOU NURSE THE BABY? ☐ YES ☐ NO DID YOU EXPERIENCE FEEDING PROBLEMS? ☐ YES ☐ NO

Breast fed? ☐ YES ☐ NO If yes, how long? _____ Formula fed? ☐ YES ☐ NO If yes, how long? _____

Which Formula(s)? _____ ❑ Don't Remember

Introduced solids at: _____ **Months** Cow's milk at _____ **Months**

Food/juice allergies or intolerances? ☐ YES ☐ NO If yes, list? _____

Does your Baby Have Colic ☐ YES ☐ NO DID YOUR BABY HAVE COLIC? ☐ YES ☐ NO

For infants / Number of Hours Sleeping per Night: _____ Quality of Sleep: ☐ Good ☐ Fair ☐ Poor

Name of Obstetrician/Midwife _____

Name of Pediatrician/Family MD _____

Date of Last Visit ^_____ Purpose _____

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Vaccinations ❑ YES ❑ NO if so which? _____ ❑ Don't Remember

*How many ear infections has the child had? During Past Six Months _____ During His/Her Lifetime_____

How were they treated? _____

*Number of Doses of Antibiotics Your Child Has Taken: During Past Six Months _____ During His/Her Lifetime_____

*Has the child ever been to a Chiropractor before? Yes ❑ No ❑ Whom? Dr. _____State_____

Date of Last Adjustment_____Purpose _____

*Has your child ever seen another holistic practitioner? Yes ❑ No ❑ Whom? Dr. _____State_____

If Yes, Please Explain _____

*Has Your Child Ever Been Treated in an Emergency Room? ❑ Yes ❑ No

If Yes, Please Explain _____

*Is your child currently under any type of treatment and/or therapy? Yes ❑ No ❑ Whom? Dr. _____State_____

If Yes, Please Explain _____

Purpose of This Appointment? _____

_____

What are your health goals for your child? _____

_____

_____
Print Name of Patient, Parent, Guardian or Personal Representative

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

CHIROPRACTIC CENTER

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AUTHORIZATION FOR CARE OF MINOR

I hereby authorize this office and its doctor(s) to administer care as they so deem necessary to my son/daughter/ward (upon approval of parent or guardian). I consent to the chiropractic treatments and assessment of my child offered or recommended to me by my chiropractor including spinal adjustment. I intend this consent to apply to my entire child's present and future chiropractic care.

I also realize that I am responsible for all fees charged by this office and I agree to pay for all services provided.

Dated this _____ day of _____, 20_____
(Day) (Month) (Year)

_____
Print Name of Patient, Parent, Guardian or Personal Representative

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date