Welcome to our practice!

Patient Information

Thank you for choosing Goffstown Chiropractic Care, PLLC for your child's chiropractic needs. If you have any questions or concerns, please do not hesitate to ask for assistance. We are happy to help.

Name: ______________________________ Social security number: ______________________

Address: ______________________ City: ______________ State: _____ Zip code: ____________

Sex: ❑ Female ❑ Male Date of birth: ______________

Who may we thank for referring you to us? ____________________________________

Responsible Party

Name of person responsible for this account: __________________ Social security number: ______________

Relationship to patient: ____________________________________

Address: ______________________ City: ______________ State: _____ Zip code: ____________

Home phone: (_____)____________ Cell phone: (_____)____________ Work phone: (_____)____________

I prefer to receive appointment reminders via: ❑ E-mail ❑ Cell phone text – my carrier is ______________________

Insurance Information

Insurance company name: ____________________________________ Phone: (_____)____________

Name of insured person (if other than patient): ______________________ Their date of birth: ____________

Relationship of insured to patient: ❑ Self ❑ Parent/Guardian ❑ Other

Insurance policy number: ________________________ Insurance group number: ______________

Symptoms

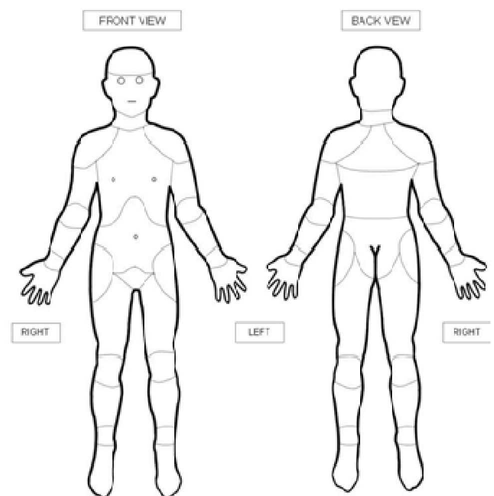
Reason for visit: ______________________________

When did you first notice your child's symptoms? ______________

How do you think your child's symptoms began? ______________

____

Indicate on the drawings to the right where your child has pain/symptoms:



How often does your child experience their symptoms?

❑ Constantly (76-100% of the time) ❑ Frequently (51-75% of the time)
❑ Occasionally (26-50% of the time) ❑ Infrequently (1-25% of the time)

How are your child's symptoms changing with time?

❑ Getting worse ❑ Staying the same ❑ Getting better

Type of pain: ❑ N/A ❑ Sharp ❑ Dull ❑ Throbbing ❑ Numbness ❑ Achiness ❑ Shooting
❑ Burning ❑ Tingling ❑ Cramps ❑ Stiffness ❑ Swelling ❑ Other: ______________

If possible, rate the severity of your child's symptoms (1 = mild pain or discomfort, to 10 = severe pain) 1 2 3 4 5 6 7 8 9 10

What aggravates your child's condition? ____________________________________

What makes your child's condition better? ____________________________________

What treatment has your child received for their condition?

❑ Medication ❑ Surgery ❑ Chiropractic ❑ Physical therapy ❑ Massage ❑ None ❑ Other ______________

History of Birth

Location of birth: ❑ Hospital ❑ Birthing center ❑ Home   Duration of gestation: _________ weeks

Was your birth assisted? ❑ Yes ❑ No ❑ Forceps ❑ Vacuum extraction ❑ C-section ❑ Induced labor

Were medications given to the mother at birth? ❑ No ❑ Yes If yes, what? ___________________________

Duration of birth: ___________________

Was the delivery uneventful? ❑ Yes ❑ No If no, what were the complications? ___________________________

Growth and Development

Was your child alert and responsive within 12 hours of delivery? ❑ Yes ❑ No If no, explain: ___________________

Age in months when your child: Responded to sound ______ Followed an object ______ Held up their head ______

Vocalized_____ Sat alone _____ Teethed _____ Crawled _____ Walked _____

Do his/her sleeping patterns seem normal? ❑ Yes ❑ No If no, explain: ___________________________

List any health conditions that exist on the mother's side of the family: ___________________________

List any health conditions that exist on the father's side of the family: ___________________________

Do the child's siblings have any health conditions? ❑ No ❑ N/A ❑ Yes If yes, describe? ___________________

Psychological Stressors

Any difficulties with lactation? ❑ No ❑ Yes If yes, what? ___________________________

Any difficulties with bonding with your child? ❑ No ❑ Yes If yes, what? ___________________________

Does your child's behavior seem normal to you? ❑ Yes ❑ No If no, describe: ___________________________

Does your child have any sleep issues? ❑ No ❑ Yes If yes, describe: ___________________________

Chemical Stressors

Mark all that applied during the mother's pregnancy: ❑ Smoked/vaped ❑ Drank alcohol ❑ Took supplements/vitamins

❑ Took drugs/medications ❑ Became ill ❑ Received ultrasounds

❑ Received invasive procedures

Was your child breast fed? ❑ No ❑ Yes If yes, for how long? ___________________________

At what age did you introduce the following to your child? Formula ______ Cow's milk ______ Solid foods _____

Did your child receive vaccinations? ❑ No ❑ Yes If yes, which ones? ___________________________

Did your child react to any of them? ❑ No ❑ Yes If yes, describe: ___________________________

Has your child had antibiotics? ❑ No ❑ Yes If yes, describe: ___________________________

Traumatic Stressors

Any evidence of birth trauma? ❑ No ❑ Yes If yes, describe: ___________________________

Did the birth mother have any injuries/falls during pregnancy? ❑ No ❑ Yes If yes, describe: ___________________

Has your child had any injuries/falls/ hospitalizations? ❑ No ❑ Yes If yes, describe: ___________________

Does your child play sports? ❑ No ❑ Yes If yes, describe: ___________________________

Patient Payment Agreement

Our policy requires payment in full for all services rendered at the time of your child's visit, unless other arrangements have been made with the doctor. I understand the above information and guarantee this form was completed correctly and to the best of my knowledge, and I understand it is my responsibility to inform this office of any changes to my child's health record.

Signature of parent/guardian ____ Date ___________________