casper chiropractic
Dr. Robyn Gotthoffer
1 Washington Blvd., Suite 6a, 2nd Fl.
Robbinsville, NJ 08691
(609) 301-7530

Pediatric New Patient Application
(Please Print)

PRE-SCHOOL CHILD HISTORY

3 to 5 Years

Today's Date: _____

Child's Name: _____ Sex: M / F Date of Birth: _____ Age: _____

Reason for Today's Visit: _____

Yes	No	
☐	☐	Does your child complain of pain or discomfort? If yes, when did this occur? _____
		Was onset Sudden ☐ or Gradual ☐ Is problem Constant ☐ or Intermittent ☐
☐	☐	Has your child ever had this problem before? _____
☐	☐	Has your child previously been treated for this problem? By whom? _____
☐	☐	Has your child previously had chiropractic care? Previous chiropractor: _____

HEALTH HISTORY

Yes	No	
☐	☐	Does your child ever complain of back or neck pain? _____
☐	☐	Does your child ever complain of pains in the arms or legs? _____
☐	☐	Does your child ever complain of headaches? _____
☐	☐	Has your child had asthma? _____
☐	☐	Is your child allergic to anything? _____
☐	☐	Are there any smokers in the child's home? _____
☐	☐	Has your child had any earaches? At what age did the child's first earache occur? _____
		How frequently does your child have earaches? _____
		In which ear do your child's earaches usually occur? Right ☐ Left ☐
☐	☐	Has your child had tubes put in his/her ears?
☐	☐	Is your child presently taking any prescribed medication? _____

Please list any other illness which have been a concern for your child: _____

_____

Please list any surgeries your child has had: _____

_____

☐ ☐ Do you have any other concerns about your child's health? _____

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TRAUMA

Yes **No**

☐ ☐ Has your child had any recent falls or trauma?

Describe the trauma and the date it occurred. _____

☐ ☐ Has your child ever fallen from a bicycle, skateboard, scooter, rollerblades or similar?

☐ ☐ Has your child ever fallen down stairs or fallen from a significant height? _____

☐ ☐ Has your child ever been in a motor vehicle collision or near-miss? _____

☐ ☐ Has your child ever had a bone fracture or joint dislocation? _____

☐ ☐ Has your child had any other trauma or injuries? _____

☐ ☐ Does your child ever bang his/her head repeatedly against a wall, bed or other object? _____

NUTRITION

☐ ☐ Do you have any concerns about your child's diet? _____

☐ ☐ Does your child have any food allergies? _____

☐ ☐ Does your child have any persistent or intermittently occurring skin rashes? _____

☐ ☐ Does your child take vitamin supplements? _____

☐ ☐ Does your child eliminate stools each day? _____

For how many months was your child breast-fed? _____

What does your child usually eat for breakfast? _____

What does your child usually eat for lunch? _____

What does your child usually eat for dinner? _____

What does your child usually eat for snacks? _____

How much cow's milk does your child drink each day? _____

What is your child's favorite food? _____

What type of fast foods does your child like to eat? _____