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

Pediatric New Patient Application
(Please Print)

SCHOOL-AGE CHILD HISTORY
6 Years to 12

Today's Date: _____

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

Reason for Today's Visit: _____

When did this problem first occur? _____

Yes	No	
☐	☐	Have you ever had this problem before? _____
☐	☐	Have you previously been treated for this problem? Doctor's name: _____
☐	☐	Have you previously been to a chiropractor? When? _____

ABOUT YOUR HEALTH

☐	☐	Back or neck pain? _____
☐	☐	Pain in the arms or legs? _____
☐	☐	Headaches? _____
☐	☐	Asthma? _____
☐	☐	Earaches? _____
☐	☐	Have you ever had tubes put in your ears?
☐	☐	Falls from a bicycle, skateboard, scooter, rollerblades or similar? _____
☐	☐	Do you ever have a problem with bedwetting? _____
☐	☐	Have you ever been in a motor vehicle accident? _____
☐	☐	Have you ever had any broken bones? _____
☐	☐	Have you ever had any surgeries? _____
☐	☐	Are you presently taking any medications? _____
☐	☐	Do you have any other health problems? _____

_____

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SCHOOL-AGE CHILD HISTORY

6 Years to 12

ABOUT YOUR LIFESTYLE

What grade are you in school? _____

How do you carry your school books? _____

How heavy is your school book bag? _____

What sports do you play? _____

What hobbies do you have _____

How many hours each day do you watch TV? _____

How many hours each day do you spend using a computer? _____

How often do yo play video games? _____

On average, how many hours of sleep do you get each night? _____

Are there any smokers in your family? _____

Do you feel stressed out? _____

Do you have trouble reading the board in class? _____

Do you ever have blurred vision? _____

Do you wear glasses or contact lenses? _____

Do you sometimes get headaches when you read? _____

ABOUT YOUR DIET

What do you usually eat for breakfast? _____

What do you usually eat for lunch? _____

What do you usually eat for dinner? _____

What snacks do you have after school? _____

What is your favorite food? _____

How much water do you drink each day? _____

How often do you eat fast food items? _____