Pediatric Intake (ages 0-17)

**Please do your best to fill out everything on this intake form. It is important that we understand past and current stressors that may have affected and could possibly continue to affect your child's overall health. It is important for us to know the following information, even if you feel it does not apply to the reason you came in for care. Please know that we value your time and aim only to provide you the best care possible. Thank you for choosing LifeLogic Health Center!*

Date: ____________________ Referred By: ________________________________

Child's Full Name: ____ Preferred Name:______________________

Parent's Name: __________________________________ Phone #: _______________________________________

Parent's Name: __________________________________ Phone #: _______________________________________

Preferred Contact Email ____

Address: ____ City: ______________________

State:________ Zip:_____________ Child's Social Security #: __________-_________-____________ Sex: M / F

Date of Birth: ______/_______/___________ Age: _________

Birth Weight: _________ Birth Length: _________in Current Weight: ____________ Current Height: _________in

Siblings' Names and Ages:

____

List your #1 health concern for your child: ____

Rate the severity of issue: (mild) 1 2 3 4 5 6 7 8 9 10 (extreme)

When did this first begin? _____________ **Date of most recent flare-up:** ___________________________________

Have they seen anyone for this issue? Y / N Whom? __________________________ **When?** ______________

What was the treatment or advice? ____

What was the result? Did it seem to work? ____

What aggravates this condition? ____

What makes it better? ____

Is it worse at certain times of the day, week or month? Y / N When? ____________________________________

Is it getting progressively worse? Y / N Does your child have flare-ups? Y / N How often? ____________

Has your child had this or something similar in the past? Y / N When?________________________________

Birth History

Mom had Morning Sickness_____ Mom had good health habits_____ Mom had poor health habits_____

Third Trimester Presentation: Vertex_____ Breech_____ Transverse_____ Face/Brow_____

Location: Home________ Birth Center________ Hospital________ Other__________________

Hours of labor________ #weeks born________ Type of Birth: Vaginal_____ Forceps_____

Cesarean_____ (elected / emergency) Suction Cup or Vacuum______ Traumatic Birth_____

Interventions: Pitocin___ Epidural___ Ruptured Membranes___ Episiotomy___ Assisted Pushing___

Developmental History

Trouble feeding from L / R side Breast Fed _____ Until_______ weeks

Formula Fed ___Y / N___ Dairy ______ Soy ______ Rice ______ Other ____________________________

Allergies: Foods_______________________ Medicines ________________ Other __________________

Food Sensitivities ____

Accidents/Falls: ____

____

Surgeries: ____

Physical, emotional, or sexual abuse: ____

Nightmares or Night Terrors Yes / No Crawled before walking Yes / No Special Diet Yes / No

Shoulder or elbow dislocation Yes / No Played in a hanging/bouncy swing Yes / No

Females: Menarche (1st menstrual cycle) Y / N If yes, Age: ______ Cramps? Yes / No

Health History

Mark each they have had in the past or have now. Put "P" for past and "N" for now.

___ Ear Infections
___ Sinus problems
___ Asthma
___ Nervous disorder
___ Decrease Range of Motion
___ Motor Integration Issues
___ Frequent infections
___ Allergies
___ Digestive problems
___ Concussion/Head injury
___ Acid Reflux/Frequent Gas
___ Sensory Integration Issues
___ Respiratory disorder/disease
___ Eczema/Skin Condition
___ Headaches (_____x/_______)
___ Neurological issues
___ Colic or Excessive Moodiness
___ Learning Issues/Disabilities
___ Other: ____

Fill in appropriate age if child has ever been diagnosed with any of the following.

Chicken Pox: age _______
Mumps: age ______
Whooping Cough: age ________
Rubella: age _______
Rubeola: age _______
Other: ____________ age ______

Has your child been to a medical doctor in the past year? Y / N   If yes, please list names and reasons below:

1.Name: ______________________________ Reason: for visit ______________________________

2.Name: ______________________________ Reason: for visit ______________________________

3.Name: ______________________________ Reason: for visit ______________________________

List *ALL* previous hospitalizations, surgeries, fractures, accidents, illnesses. (Use back of page if necessary)

1. Issue______________________________ When ____________ Hospitalized? Y / N
2. Issue______________________________ When ____________ Hospitalized? Y / N
3. Issue______________________________ When ____________ Hospitalized? Y / N

Chemical History

Vaccinations: None _____/ Some (please list below) ______/ Delayed Schedule _____/ Full Schedule _____

____

Number of doses of antibiotics you have given your child:
During the past six months: _____ During his/her lifetime: _____
For what? ____

Number of doses of other prescription medications you have given your child:
During the past six months: _____ During his/her lifetime: _____
For what? ____

Number of doses of over the counter medications you have given your child:
During the past six months: _____ During his/her lifetime: _____
For what? ____

Child's Diet / Mom's Diet if Breastfeeding

	Daily/High	Weekly/Moderate	Monthly or less/Low	None/Never
Dairy	_____	_____	_____	_____
Meat	_____	_____	_____	_____
Wheat/Breads	_____	_____	_____	_____
Other Grains	_____	_____	_____	_____
Vegetables	_____	_____	_____	_____
Fruit	_____	_____	_____	_____
Soy	_____	_____	_____	_____
Sugar	_____	_____	_____	_____
Soda/Energy Drinks	_____	_____	_____	_____
Fast food	_____	_____	_____	_____
Candy	_____	_____	_____	_____
Water	_____	_____	_____	_____

Chiropractic Care History

Does your family currently receive chiropractic care? Y / N If no, have they in the past? Y / N

Has your child ever been adjusted? Y / N Doctor or Office Name: ________________________________
When? _________________________________ Duration of care: _________________________________

Reason for visit: _________________________ Result: ____

Technique used: _________________________ Last Adjustment: _________________________________

Social / Sports History

Has your child been involved in any of the following? "P" for Past, "N" for Now.
___ Soccer ___ Football ___ Gymnastics ___ Baseball ___ Basketball ___ Cheerleading ___ Martial Arts ___ Ballet ___ Dance/ Tap ___ Hockey (___ice ___field) ___ Tennis ___ Swimming ___ Biking ___ Track/ Running ___ Lacrosse
___ Marching Band/ Colorguard ___ Golf ___ Wrestling ___ Volleyball
Other: _____________________________

Is there anything else which may help us understand the patient, their history, or their needs which has not been covered in this intake? Please explain: ____

____

____

Legal Agreements

I agree that a photocopy or facsimile of any document I sign for LifeLogic Health Center, LLC will be deemed as valid and binding on all parties involved as if the photocopy was the original document I sign.

Signature: ____ Date: ________________________________

With my signature, I verify that I have gone to the U.S. Department of Health & Human Services website at **http://www.hhs.gov/ocr/privacy/** to review my health information privacy rights. I understand that I can ask the doctors in the office if I have any questions regarding my HIPAA rights.

Signature: ____ Date: ________________________________

Accuracy of Information

I hereby authorize the doctors at LifeLogic Health Center to administer chiropractic services to my son / daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Parent/ Guardian Name: ____________________________________

Signature: ____ Date: ______________________