

PEDIATRIC INTAKE FORM

Date: _____

PERSONAL INFORMATION

Child's First Name: _____ Last Name: _____

Address: _____

City/State/Zip: _____

Date of Birth: _____ Age: _____ Sex: M F

Parent's Names: _____

Best Contact Phone Number: _____ Alt. Phone: _____

Email: _____ Referred By: _____

Has your child seen a chiropractor before? YES NO

How long ago? _____

HEALTH HISTORY

Describe the health concern that prompted this visit: _____

When did this concern begin? _____

Has this condition: Stayed the same Been Intermittent Worsened

Does this interfere with: Sleep Daily Routine School

Has your child seen anyone else for this concern? YES NO

Type of Treatment: _____

Are there any more injuries and/or surgeries? _____

Please list any medications your child is currently taking and dosage (including OTC): _____

Please **CIRCLE** any of the following conditions your child has suffered from during the last six months:
Ear Infections Scoliosis Seizures Chronic Colds Headaches Asthma/Allergies
ADHD Recurring Fevers Digestive Problems Colic Bed Wetting Temper Tantrums

BIRTH INFORMATION

Child's birth was at: Home Birthing Center Hospital

OB/Midwife/Physician was: _____

Child Birth was: Natural vaginal with no medications
 Vaginal with interventions: Pitocin Epidural Pain Medications
 Vacuum Extraction Forceps IV antibiotics
 C-Section: Scheduled Emergency
 Adopted Prenatal History unknown Birth History unknown

Was your child at anytime during pregnancy in a constrained position? YES NO UNSURE
If yes, please describe: Breech Transverse Face/Brow presentation

Complications during pregnancy: YES NO (If yes, describe) _____

Birth Weight: _____ Birth Length: _____ APGAR Score: _____

Ultrasounds used during pregnancy? YES NO Number of times: _____

FEEDING HISTORY

Did you breastfeed the baby? YES NO If yes, how long: _____

Did you formula-feed the baby? YES NO If yes, how long: _____

At what age did you introduce: Solids: _____ Cow's Milk: _____

Food Allergies or Intolerance: YES NO

List: _____

DEVELOPMENTAL HISTORY

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:

_____ Respond to sound	_____ Cross Crawl
_____ Respond to visual stimuli	_____ Stand Alone
_____ Hold head up alone	_____ Walk Alone
_____ Sit up alone	

According to the National Safety Council, approximately 50% of child 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? YES NO

Explain: _____

Please list any major injuries, accidents, falls and/or fractures: _____

Vaccination History (**PLEASE CIRCLE**): Unvaccinated due to Age Unvaccinated Exemption/Waiver
Delayed Vaccination Schedule Up to date for Age

CHILDHOOD DISEASES

Please indicate if your child has had any of the following:

- | | |
|--------------------------------------|---|
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Rubella | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Rubeola | <input type="checkbox"/> Other : _____ |

REVIEW OF SYSTEMS

Please check the corresponding boxes for each symptom or condition your child has experienced - including both past and present.

REGIONS	FUNCTIONS	SYMPTOMS					
		PAST	PRESENT	PAST	PRESENT		
Cervical	· Autonomic Nervous System	<input type="checkbox"/>	<input type="checkbox"/>	Ear & Sinus Infections	<input type="checkbox"/>	<input type="checkbox"/>	TMJ/Jaw Pain
	· ENT System	<input type="checkbox"/>	<input type="checkbox"/>	Allergies & Congestion	<input type="checkbox"/>	<input type="checkbox"/>	Stiff Neck
	· Vision, Balance & Coordination	<input type="checkbox"/>	<input type="checkbox"/>	Colic & Excessive Crying	<input type="checkbox"/>	<input type="checkbox"/>	ADD/ADHD
	· Speech	<input type="checkbox"/>	<input type="checkbox"/>	Headaches & Migraines	<input type="checkbox"/>	<input type="checkbox"/>	Depression
	· Immune System	<input type="checkbox"/>	<input type="checkbox"/>	Vertigo & Dizziness			
	· Digestive System	<input type="checkbox"/>	<input type="checkbox"/>	Sore Throat & Strep			
	· Nerve Supply to Shoulders, Arms & Hands	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Tonsils & Adenoids			
	· Sympathetic Nucleus	<input type="checkbox"/>	<input type="checkbox"/>	Vision & Hearing Issues			
	· Metabolism	<input type="checkbox"/>	<input type="checkbox"/>	Low Energy & Fatigue			
			<input type="checkbox"/>	<input type="checkbox"/>	Focus & Memory Issues		
Thoracic	· Upper G.I.	<input type="checkbox"/>	<input type="checkbox"/>	Reflux/ GERD	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Issues
	· Respiratory System	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Colds & Cough	<input type="checkbox"/>	<input type="checkbox"/>	Gas Pain
	· Cardiac Function	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Bloating
	· Major Digestive Center	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis & Pneumonia			
	· Detox & Immunity	<input type="checkbox"/>	<input type="checkbox"/>	Function Heart Conditions			
	· Stress Response	<input type="checkbox"/>	<input type="checkbox"/>	Indigestion & Heartburn			
	· Filtration & Elimination	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice			
	· Gut & Digestion	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Pain/Ulcer			
Lumbar, Sacrum & Pelvis	· Lower G.I. (Absorption & Motility)	<input type="checkbox"/>	<input type="checkbox"/>	Bed-Wetting	<input type="checkbox"/>	<input type="checkbox"/>	Constipation
	· Gut- Immune System	<input type="checkbox"/>	<input type="checkbox"/>	Bladder Conditions	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea
	· Major Hormonal Control	<input type="checkbox"/>	<input type="checkbox"/>	Urination Issues	<input type="checkbox"/>	<input type="checkbox"/>	Knee Pain
		<input type="checkbox"/>	<input type="checkbox"/>	Cramps & Menstrual Issues	<input type="checkbox"/>	<input type="checkbox"/>	Ankle Pain
				<input type="checkbox"/>	<input type="checkbox"/>	Low Back Pain	

AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize this office and its Doctors to administer care 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.

Child's Name: _____ Date: _____

Parent Name: _____

Parent Signature: _____

Witnessed: _____