Date_____________

Pediatric Intake Form

Whom may we thank for referring you:___________________________________

Last Name:____________________________ First:________________________ SS#____________________

Address:__________________________City:_______________State:_____ Zip:__________ Date of Birth:__________Age:____

Email:_________________________________Phone: Cell ______________________ Home_________________

Mother's Name:_________________________Father's Name:____________________________

Prior Chiropractic Care:

Doctor's Name:___________________________ Clinic Name:___________________________ Phone:____________________

For how long:____________Results Achieved: ☐ Excellent ☐ Good ☐ Fair ☐ Poor ____________________

X-rays taken: ☐ yes ☐ no If so, when:______________What areas:_______________

Medical Doctor:

Doctor's Name:___________________________ Clinic Name:___________________________ Phone:____________________

Doctor's Name:___________________________ Clinic Name:___________________________ Phone:____________________

Other Healthcare Providers:

Doctor's Name:____________________________ Profession:___________________________ Phone:____________________

Doctor's Name:____________________________ Profession:___________________________ Phone:____________________

Health Proflle:

Why is this important?

As a family chiropractic office, we focus on your child's ability to be healthy.
Our goals are first to address the reason that brought you to this office, and second, to offer you and your child the opportunity of improved health potential and wellness service.

Reason for Visit:

The reason(s) that have prompted you to seek care for your child today:____

____

When did you first start noticing this?___________________________Cause?____

How often does this occur?____

Is this interfering with: ☐ School ☐ Sleep ☐ Walking ☐ Other__________________________

Other Doctors seen for this reason?____

What over the counter medications, herbs, supplements, etc. is your child is taking?_______________________________

Number of doses of antibiotics your child has taking?______________Past 6 months_____Reason____________________________

What prescriptions is your child is taking?________________________Past 6 months_____Reason____________________________

Has your child had surgery? ☐ yes ☐ no What?_____________________________ When?_________________________

How would you rate your child's overall health?

Worst he/she has ever been — Best he/she has ever been

Place an X on the line where you perceive they are overall.

Daily we experience physical, chemical, and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual and begin very early in life. Answering the following questions will give us information that will allow us to better assess the challenges to your child's health potentail.

Pregnancy:

Were there any complications to the pregnancy?______________________________

Was Mom on any medications, prescription or over-the-counter ☐ yes ☐ no
If yes, explain:______________________________

Did Mom or Dad smoke during pregnancy? ☐ yes ☐ no Who?_______________

Was the baby ever in the Breech position? ☐ yes ☐ no

How many ultrasounds were performed?_______________

Birth and Delivery:

Where was the baby born?: ☐ Home ☐ Hospital ☐ Birthing Center ☐ Other_______________

Was the delivery: ☐ Vaginal ☐ C-Section Were any devices used? ☐ Forceps ☐ Vacuum

How long was the labor?_______________ How was the delivery?______________________________

Was oxytocin/pitocin used? ☐ yes ☐ no Was an epidural administered? ☐ yes ☐ no

Infancy:

Was the infant vaccinated? ☐ yes ☐ no Any adverse reactions? ☐ yes ☐ no If so, what?_______________
To which vaccines?______________________________

Was there any prolonged use of medications or an inhaler? ☐ yes ☐ no If so, which_______________

Did the infant suffer any traumas such as serious falls or car accidents? ☐ yes ☐ no

Childhood Years:

Did the child have any childhood illnesses? ☐ yes ☐ no Explain:______________________________

Does the child play youth sports? ☐ yes ☐ no Which sport(s):______________________________

Has the child fallen from a height over 3 ft.? ☐ yes ☐ no Explain:______________________________

Was the child involved in any car accidents? ☐ yes ☐ no Explain:______________________________

Has there been any prolonged use of meds? ☐ yes ☐ no Explain:______________________________

Has the child suffered emotional traumas? ☐ yes ☐ no Explain:______________________________

Please give us any any other health information you feel would be helpful:______________________________

____

____

YOUR GOALS FOR YOUR CHILD'S CARE:

- ☐ Feel better quickly/pain relief.
- ☐ Have a healthier spine.
- ☐ Feel better and prevent its return.
- ☐ Optimum health and to live a healthier lifestyle.

We invite you to discuss with us any questions regarding our services. The best health services are based upon a friendly, mutual understanding between our team and yourself. Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with our office.

The statements made on this form are accurate to the best of my recollection and I request and give consent to this office to chiropractically examine and care for my child.

Parent's Signature______________________________ Date_______________