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

- □ Chicken Pox
- □ Rubella
- □ Rubeola
- □ Whooping Couch
- □ Mumps
- □ 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
Cervical	· Autonomic Nervous System	Ear & Sinus Infections	☐	☐
	· ENT System	Allergies & Congestion	☐	☐
	· Vision, Balance & Coordination	Colic & Excessive Crying	☐	☐
		Headaches & Migraines	☐	☐
	· Speech	Vertigo & Dizziness	☐	☐
	· Immune System	Sore Throat & Strep	☐	☐
	·Digestive System	Swollen Tonsils & Adenoids	☐	☐
	· Nerve Supply to Shoulders, Arms & Hands	Vision & Hearing Issues	☐	☐
		Low Energy & Fatigue	☐	☐
	· Sympathetic Nucleus	Focus & Memory Issues	☐	☐
	· Metabolism	Difficulty Sleeping	☐	☐
		Epilepsy & Seizures	☐	☐
		Speech Issues	☐	☐
Thoracic	· Upper G.I.	Reflux/ GERD	☐	☐
	· Respiratory System	Chronic Colds & Cough	☐	☐
	· Cardiac Function	Asthma	☐	☐
	· Major Digestive Center	Bronchitis & Pneumonia		
	· Detox & Immunity	Function Heart Conditions		
	· Stress Response	Indigestion & Heartburn		
	· Filtration & Elimination	Jaundice		
	· Gut & Digestion	Stomach Pain/Ulcer		
Lumbar, Sacrum & Pelvis	· Lower G.I. (Absorption & Motility)	Bed-Wetting	☐	☐
		Bladder Conditions	☐	☐
	· Gut- Immune System	Urination Issues	☐	☐
	· Major Hormonal Control	Cramps & Menstrual Issues	☐	☐

SYMPTOMS	PAST	PRESENT
TMJ/Jaw Pain	☐	☐
Stiff Neck	☐	☐
ADD/ADHD	☐	☐
Depression	☐	☐
Kidney Issues	☐	☐
Gas Pain	☐	☐
Bloating	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐
Knee Pain	☐	☐
Ankle Pain	☐	☐
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: _____