Pediatric Intake Form

Patient Information

Today's Date:_____
Child's name _____ Date of Birth:_____
Social Security#_____ Age:_____ ☐ Female ☐ Male
Names of Parents: _____
Address: _____ City:_____ State:_____ Zip code:_____
Home#:_____ Cell#:_____ E-mail :_____
Preferred Method of Contact: ☐ Home# ☐ Cell# ☐ E-mail
Payment for Services will be made by:
☐ Cash ☐ Check ☐ Credit Card ☐ Health Insurance

Health Insurance Information

Name of Insured :_____ Insured's Date of Birth:_____
Name of Insurance Co:_____ Insured's Social Security #:_____
Insured Employer:_____ Employer's Phone#:_____

Prenatal History

Is your child adopted? ☐ Yes ☐ No
Did the mother have any injuries during the pregnancy (accidents, falls, etc.)? ☐ Yes ☐ No
Cigarette/alcohol use during pregnancy? ☐ Yes ☐ No If yes, type:_____ amount:_____
Was ultrasound used during this pregnancy? ☐ Yes ☐ No Frequency:_____
Were there complications during this pregnancy? ☐ Yes ☐ No Explain:_____
Was there any drugs or medications taken during pregnancy? ☐ Yes;_____ ☐ No

Birth History

Check all that occurred at delivery of this child:

☐ Vaginal delivery	☐ Planned C-section	☐ Emergency C-section
☐ Face presentation	☐ Forceps/vacuum	☐ Induced Labor/Pitocin
☐ Breech Presentation	☐ Anesthesia/Epidural	☐ Neonatal Intensive Care
☐ Premature delivery	☐ Delivery of multiples	☐ Home birth/water birth

Birth Height:_____ Birth Weight:_____

Medical Health History

Has your child ever suffered from: (check all that apply)

☐ Allergy/Asthma	☐ Major Falls/injuries	☐ Ear infections
☐ Hyperactivity	☐ Recurrent antibiotic use	☐ Anxiety Disorders
☐ Bedwetting	☐ Anemia/Blood disorders	☐ Hospitalization
☐ Arthritis/ joint pain	☐ Behavioral problems	☐ Dizziness/ Fainting
☐ Heart trouble	☐ Digestive problems/constipation	☐ Seizures
☐ Colic	☐ Low blood pressure	☐ Extremity pain
☐ Tuberculosis	☐ Poor appetite	☐ Headaches
☐ Diabetes	☐ Sinus Headaches	☐ Back pain
☐ Growing pains	☐ Fractures	☐ Other:_____

During infancy this child was: ☐ breast fed (____ months) ☐ formula fed (____ months)
What is the vaccination schedule for this child? ☐ Standard ☐ Alternative ☐ None
How many hours of sleep does this child get per night?_____ Quality: ☐ good ☐ fair ☐ poor

What sleep positioning does this child prefer? ☐ stomach ☐ back ☐ left side ☐ right side
Has this child ever been seen by a chiropractor? ☐ Yes;_____ ☐ No
Is this child currently taking any medication? ☐ Yes;_____ ☐ No
Is this child currently taking any vitamins? ☐ Yes;_____ ☐ No

Baby /Toddler (0-4)

Have any of the following occurred?

☐ fall from changing table ☐ frequent crying spells ☐ tumble down stairs ☐ fall from crib
☐ genetic disorder ☐ frequent ear infections ☐ frequent diarrhea ☐ colic
☐ feeding difficulties ☐ reaction to vaccines ☐ frequent fevers ☐ constipation
☐ repeated infections/colds ☐ difficulty turning head ☐ (+ or -) weight gain ☐ reflux
☐ other:_____

Child (5-12)

Have any of the following occurred?

☐ fall from tree ☐ fall off bicycle ☐ fall on playground ☐ stomach pains
☐ hyperactivity ☐ learning difficulties ☐ bed wetting ☐ scoliosis
☐ sports injury/accident ☐ frequent ear infections ☐ allergies ☐ autism
☐ repeated infections/colds ☐ leg/knee pains ☐ growing pains ☐ asthma
☐ other:_____

Teen (13-17)

Have any of the following occurred?

☐ car accident ☐ sports injury/accident ☐ stomach pains ☐ pregnancy
☐ hyperactivity ☐ headaches ☐ acne ☐ asthma
☐ repeated infections/colds ☐ learning difficulties ☐ scoliosis ☐ allergies
☐ poor coordination ☐ poor balance ☐ poor posture ☐ concussion
☐ other:_____

Current Health Concern Information

If you are here to find out if your child is subluxated and your child does not seem to be suffering from an illness or condition, proceed to the top of the next page.

Reason(s) for consulting our office?_____
When did this condition begin?_____ Was it the result of an injury? ☐ Yes ☐ No
Has he/she had similar problems before? ☐ Yes ☐ No When?_____
Do you feel the condition is: ☐ staying the same ☐ getting worse ☐ getting better
☐ a constant aggravation ☐ comes and goes
What does this condition interfere with? ☐ School ☐ Sleep ☐ Play ☐ Other_____
Which activities aggravate the problem? _____
What makes the condition better? _____
Do you know what caused this problem?_____
Describe any other health problem(s) :_____
Is this child currently being treated by a physician for the above health problems? ☐ Yes ☐ No
Previous fractures (location/date) :_____
Previous surgeries: (including tubes in ears, tonsils, dental, etc.)
1)_____ Date:_____ 2)_____ Date:_____
Previous Accidents:
1)_____ Date:_____ Auto Sport Fall
2)_____ Date:_____ Auto Sport Fall

Did this child meet all developmental milestones (sit up, crawl, walk, etc) ☐ Early ☐ On Time ☐ Late
Does this child live in a smoking environment? ☐ Yes ☐ No
Does this child have good concentration? ☐ Yes ☐ No
Is this child well-coordinated? ☐ Yes ☐ No
Does this child have good posture? ☐ Yes ☐ No
Is this child a 'picky' eater? ☐ Yes ☐ No
How would you rate this child's diet? ☐ Well Balanced ☐ Average ☐ High sugar/Processed

Physical/Emotional/Chemical Stress Test

The following areas of stress can cause misaligned vertebrae (subluxation).
Which of these stresses do you feel are affecting your child's health? Check all that apply:

☐ Birth trauma	☐ Slips/Falls	☐ Auto accident(s)	☐ Sports injury
☐ Physical abuse	☐ Poor posture	☐ Extensive computer work	☐ Learning difficulties
☐ Sleeping on couch	☐ Pollution/vapors	☐ Repetitive lifting/bending	☐ Poor concentration
☐ Continuous sitting	☐ Poor sleep	☐ Concealed feelings	☐ Quick Tempered
☐ Caffeine	☐ 2nd hand smoke	☐ Poor diet/excessive sugar	☐ Artificial sweeteners
☐ Allergies	☐ Prescription drugs	☐ Over the counter drugs	☐ Excessive video games
☐ Heavy backpack	☐ Television/movies		

Wellness Profile

Are you committed to not only eliminating symptoms, but what caused them, even if it requires a change in your child's lifestyle? ☐ Yes ☐ No
Chiropractic care affects more than just your muscles and bones. What health goals do you hope to find for yourself? Check all that apply:

☐ more energy	☐ better sleep	☐ freedom from pain
☐ easier breathing	☐ balanced posture	☐ improved nutrition
☐ improved coordination	☐ improve overall health	☐ reduce medications
☐ better sports performance	☐ better concentration	☐ enhanced emotional well-being
☐ high resistance to disease	☐ relief from symptoms	☐ other_____

Name of Medical Pediatrician:_____
Location:_____
Phone Number:_____

By signing below, I declare that the above information is exact and completed to the best of my ability.

Guardian Signature:_____ Date:_____

Relationship to Patient:_____

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Accept patient for treatment ☐ Yes ☐ No

Doctor Signature:_____