



# PEDIATRIC INTAKE FORM

## PATIENT INFORMATION

Patient Name _____	Mother's Name _____
Address _____	Mother's Occupation _____
City _____ State _____ Zip _____	Mother's Phone _____
Home Phone _____	Mother's Email _____
Cell Phone _____	
Email _____	Father's Name _____
Sex M F Age _____ Birthday _____	Father's Occupation _____
<b>IN CASE OF EMERGENCY, CONTACT</b>	Father's Phone _____
Name _____	Father's Email _____
Relationship _____	<b>Who may we thank for referring you?</b>
Contact Number _____	_____

## HOW CAN WE HELP YOUR CHILD?

Wellness Checkup     Other: \_\_\_\_\_

If your child is already experiencing a symptom, please describe it:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Has your child been treated on an emergency basis?     Yes     No

Please describe: \_\_\_\_\_

## PREGNANCY HISTORY

Did you experience any complications during your pregnancy? (check all that apply)

<input type="checkbox"/> Back/Other Pain	<input type="checkbox"/> Gestational Diabetes	<input type="checkbox"/> Pre/Eclampsia	<input type="checkbox"/> Strep B	<input type="checkbox"/> Nausea/Vomiting
<input type="checkbox"/> Pre-Term	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Swelling	<input type="checkbox"/> Other (please describe) _____	

## BIRTH HISTORY

Type of birth (check all that apply):

<input type="checkbox"/> Hospital	<input type="checkbox"/> Birth Center	<input type="checkbox"/> Home	<input type="checkbox"/> Normal / Vaginal	<input type="checkbox"/> Breech
<input type="checkbox"/> Cesarean	<input type="checkbox"/> Scheduled/Induced	<input type="checkbox"/> Epidural		

Problems during labor / delivery? \_\_\_\_\_

\_\_\_\_\_

<input type="checkbox"/> Antibiotics	<input type="checkbox"/> Congenital Anomalies	<input type="checkbox"/> Failure to Thrive	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Meconium
<input type="checkbox"/> Respiratory Distress	<input type="checkbox"/> Extended Hospitalization	<input type="checkbox"/> Other _____		

## GROWTH & DEVELOPMENT

Infant feeding:  Breast  Bottle  Formula

Number of hours of sleep each night: \_\_\_\_\_ Quality of sleep: \_\_\_\_\_

At what age did the child: \_\_\_\_\_

Respond to sound: \_\_\_\_\_ Crawl: \_\_\_\_\_ Hold head up: \_\_\_\_\_

Stand: \_\_\_\_\_ Sit unsupported: \_\_\_\_\_ Walk unsupported: \_\_\_\_\_

## CHILDHOOD DISEASE, ILLNESS & VACCINATIONS

Has your child had (check all that apply)?:

- Chicken Pox  Measles  Rubiola  
 Mumps  Rubella  Pertussis/Whooping Cough

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

- Allergies  Broken Bones  Digestive Issues (constipation/diarrhea)  Hypertension  Orthopedic Problems  
 Anemia  Chronic Ear Aches  Juvenile / Rheumatoid Arthritis  Paralysis  
 Arm Problems  Colds/Flu  Dizziness  Joint Problems  Poor Appetite  
 Asthma  Colic  Fainting  Leg Problems  Ruptures/Hernias  
 Back Aches  Convulsions/Seizures  Headaches  Neck Problems  Sinus Trouble  
 Bed Wetting  Delayed Speech  Heart Trouble  Neuritis  Tuberculosis  
 Behavioral Problems  Diabetes  Hyperactivity  Walking Problems

Have you vaccinated your child?

- No  Yes  As Scheduled  Delayed Schedule  COVID Vaccine

## ALLERGIES, MEDICATIONS, SURGERIES, & FAMILY HISTORY

ALLERGIES (list)

\_\_\_\_\_  
\_\_\_\_\_

MEDICATIONS (list)

\_\_\_\_\_  
\_\_\_\_\_

SURGERIES (list)

\_\_\_\_\_  
\_\_\_\_\_

FAMILY HISTORY (list)

\_\_\_\_\_  
\_\_\_\_\_

## SIBLINGS

How many children do you have? \_\_\_\_\_ Number of pregnancies: \_\_\_\_\_

Children's Ages: \_\_\_\_\_ Are you currently pregnant?  No  Yes, I'm due: \_\_\_\_\_

Children's health concerns: \_\_\_\_\_ Health concerns regarding this pregnancy? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

### Authorization for Care of Minor

I hereby authorize this clinic and its doctor(s) to administer care as they so deem necessary to my son/daughter/ward.

Parent/Guardian Signature: \_\_\_\_\_ Witnessed: \_\_\_\_\_ Date: \_\_\_\_\_

**According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e. a bed, changing table, down stairs).**

Did your child have a fall similar to what was described above?  Yes  No

Explain: \_\_\_\_\_

Has your child been involved in any sports?  Yes  No List: \_\_\_\_\_

Please list all past broken bones, surgeries or hospitalizations: \_\_\_\_\_

\_\_\_\_\_

Other traumas not listed: \_\_\_\_\_

Is there anything else you would like us to know about your child?  
\_\_\_\_\_

**FAMILY HISTORY:**

Does anyone in your family been diagnoses with:  Heart Disease  High Blood Pressure  Kidney Disease  Lung Disease  Diabetes  High Cholesterol  Asthma  Cancer  Stroke  Alzheimer's/dementia  Osteoporosis  Genetic Disorder

Please list child, spouse, sibling, mother, and/or father and diagnosis: \_\_\_\_\_

\_\_\_\_\_

**EXPERIENCE WITH CHIROPRACTIC:**

Have your child seen a Chiropractor before?  Yes  No Reason for visits: \_\_\_\_\_

Favorable outcomes?  Yes  No Explain: \_\_\_\_\_

Are you aware of any poor posture habits of your child/children?  Yes  No Explain: \_\_\_\_\_

Do you have other children that have not had their spines checked?  Yes  No

**ACKNOWLEDGMENTS: Please read each statement and initial your agreement on the left.**

**Insurance Information**

\_\_\_\_\_ I clearly understand that all insurance coverage is an arrangement between my insurance carrier and me. If this office chooses to bill any services to my insurance carrier that they are performing these services strictly as a convenience for me. This office will provide any necessary report or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny any claim and that I am ultimately held responsible for any unpaid balances. Any monies received will be credited to my account.

**Privacy Policy**

\_\_\_\_\_ I understand and have been provided with the opportunity to review a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations.

**Appointment Reminders and Health Care Information Authorization**

\_\_\_\_\_ Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

**By signing below, you are acknowledging that to the best of your ability, the information you have supplied is complete and truthful. You have not misrepresented the presence, severity, or cause of your health concern.**

\_\_\_\_\_  
Parent / Guardian Signature

Date

\_\_\_\_\_  
Doctor Signature

Date

This information is confidential. If we do not sincerely believe your problem will respond favorably, we will not be able to accept your case. We will refer you to a health professional we believe will help you. In order for us to understand your health problems properly, please make sure you completed this form neatly, accurately, and completely.