PEDIATRIC CHIROPRACTIC INTAKE FORM

Thank you for allowing us the opportunity to take care of you and your family. Please complete the following information so we can better serve your child. It is a pleasure to welcome you to our chiropractic family.

Child's Name____DOB_____/_____/_____Age_____________

Sex M / F Height______________ Weight______________ # of Siblings_____________________________

Name of Parents/Guardians____

Address____City/State/Zip______________________________

Mother's Cell__________________________________ Father's Cell___________________________________

Parent email____

How did you hear about our office?____

Reason for today's visit____

Other doctors you have seen for this visit____

Prior treatment____

OTHER HEALTH PROBLEMS

Please check any current or past health problems your child has had on the list below:

___Dizziness	___Diabetes	___Anemia	___Broken bones
___ADHD	___Rheumatic Fever	___TB	___Sprains/strains
___Autism	___Poor appetite	___Fainting	___Hypertension
___Backaches	___Hyperactivity	___Arthritis	___Hernia
___Neck pain	___Elbow/arm pain	___Heart condition	___Behavioral issues
___Headaches	___Rashes	___Poor memory	___Leg/hip pain
___Allergies	___Digestive issues	___Insomnia	___Knee/foot pain
___Asthma	___Sinus issues	___Nightmares	___Growing pains
___Runny nose	___Neuritis	___Bed wetting	___Joint pain
___Itchy eyes	___Cough/Wheeze	___Pain while urinating	___Scoliosis
___Chronic ear infections	___Chest pain	___Convulsions	___Blood disorders
___Frequent colds	___Constipation	___Paralysis	___Stomachaches
___Fever/chills	___Diarrhea	___Muscle pain	___Other__________

HEALTH HISTORY

Previous chiropractor______________________________Reason for care____________________________

Name of pediatrician______________________________Date of last visit___________________________

Reason for last visit____

Current medications____

Has your child been injured in any type of accident (i.e. sports, car accident, major fall, etc) Y / N

If yes, please describe with dates____

____

Prior surgeries with dates____

____

PRENATAL HISTORY
Childbirth caregiver(s): OB/GYN____________ Doula________________ Midwife_________________
Location of birth: Hospital_________________ Home_______________ Birth Center______________
Medication used during birth: None__________ Pitocin______________ Epidural_________________
Interventions during birth: Breaking water______________ Vacuum_______________ Forceps_________________
Position of baby at birth: Head down__________________ Posterior______________ Breech__________________
Length of labor:__________________
Complications during pregnancy____
Complications during delivery____
Birth weight_____________________ Birth height______________________________________

FEEDING HISTORY
Breast fed: Y / N How long_________________________________
Formula fed: Y / N How long________________________________
Type of formula____
Introduced solids at _________ months Cow's milk at ___________ months
Food allergies/intolerances Y / N ____

DEVELOPMENTAL HISTORY
Number of hours of sleep per night ______ Quality of sleep: Good / Fair / Poor
At what age was your child able to:

Respond to sound_____ Follow object with eyes_____ Hold head up_____
Crawl_____ Sit alone_____ Roll over_____
Walk alone_____ Say words_____

WE ARE HERE TO SERVE YOU AND ENCOURAGE YOU TO ASK QUESTIONS.
YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR CHILD'S RESULTS.

Insurance carrier____
Policy holder name____ DOB______________________________

AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize this office and its Doctor(s) 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.

____
Parent/guardian print Signature Date

Pediatric Functional Form

Child's name:_______________________________________

Today's date:_______________________________________

Please check all those that apply to your child.

_______1. Has your child been more irritable?
_______2. Has your child had difficulty sleeping?
_______3. Has your child's sleeping pattern changed?
_______4. Has your child's digestion pattern changed (i.e. constipation/diarrhea)
_______5. Has your child's intake of food been less or more?
_______6. Has your child needed more parental attention/affection?
_______7. Has your child been more distant/less affectionate?
_______8. Has your child had trouble with learning or retaining information?
_______9. Has your child's attention or focus been shortened?
_______10. Has your child's balance or coordination been altered?
_______11. Have you noticed any changes in speech patterns?
_______12. Have you noticed any changes in breathing patterns?
_______13. Have you noticed any visional changes such as squinting?
_______14. Have you noticed a change in "playing" patterns?
_______15. Have you noticed any aggression/violence/acting out?
_______16. Have you noticed any changes in relationships with grandparents/daycare providers/teachers?

_______Score