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# PEDIATRIC INTAKE FORM

First Name ______________________ Last Name ______________________

Age ______ Birthdate __________ Parent/Guardian's Name ______________________

Home Phone # ______________________ Cell Phone # ______________________

Address ____________________________________________

Email Address ____________________________________________

City ______________ State ______________ Zip Code ______________

Siblings ______________________ Health Issues ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

Reason for Visit ____________________________________________

Other methods of treatment attempted & the result of each ______________________

____________________________________________

Previous chiropractic care? ☐ Yes ☐ No

## PATIENT HISTORY:

### IN UTERO COMPLICATIONS *(Check all that apply)*

- ☐ Difficulty Conceiving __________
- ☐ Breached Positioning __________
- ☐ Bleeding/Spotting __________
- ☐ Cramping/Braxton Hicks __________
- ☐ Bed Rest (how far along) __________
- ☐ Prescription Medications Used __________
- ☐ Other ______________________

### STRESSORS DURING LABOR *(Check all that apply)*

- ☐ Induced (Pitocin/Oxytocin Injection)
- ☐ Vacuum Extraction
- ☐ Forceps Utilized
- ☐ Epidural (epidorual analgesia)
- ☐ Breached Positioning
- ☐ Slow Birth or Stuck in Canal
- ☐ Unresponsive or Low Apgar Score Following Delivery __________
- ☐ C-Section
- ☐ Other ______________________

# PATIENT HISTORY (CONT.):

## PATIENT DIETARY HABITS *(Check all that apply)*

- ☐ Breast Fed (how long) ______________________ Currently? Yes No
- ☐ Formula Fed (how long) ______________________ Currently? Yes No
- ☐ Picky Eater (preferred foods) ______________________
- ☐ Doesn't like ______________________
- ☐ Consumes Milk (type) ______________________
- ☐ Consumes Water (how much, how often) ______________________
- ☐ Effects on Bowel Function ______________________

## DOES YOUR CHILD HAVE OR HAD IN THE PAST ANY OF THE FOLLOWING SIGNS OF NERVOUS SYSTEM STRESS *(Check all that apply)*

- ☐ Slow to reach milestones: sitting, crawling, walking, crawled "funny"
- ☐ Asymmetrical or flattening of the cranium/skull? Front Back Sides
- ☐ Lack of hair growth on the cranium
- ☐ Only turns or prefers head to turn in only one direction
- ☐ Failure to latch, difficulty breast feeding
- ☐ Inability to soothe, irritable, stiff, high-pitched screams
- ☐ Foot/Feet turn inward or outward with standing or crawling? R / L In / Out
- ☐ Digestive issues: bloating, gassy, heartburn, colic, indigestion, vomiting, reflux, spit-up
- ☐ Constipation (less than once a day, struggles, hard pebbles)
- ☐ Diarrhea (loose stool)
- ☐ Growing pains, back pain, hip pain, knee pain, foot pain, arm pain, hand pain
- ☐ Not hitting milestone as deemed "normal"
- ☐ Behavioral issues: ADD ADHD OCD Depression Anxiety Asperger's
- ☐ Neurological disorders: numbness/tingling, weakness, CP, autism, seizures
- ☐ Poor quality sleep (toss and turns, troubles getting to sleep, not rested in AM)
- ☐ Suppressed immune system function/sickly (more than 2 times a year)
- ☐ Cough, cold, congestion, ear infestions, sinus infections, recurrent infections
- ☐ Other ______________________

How many rounds of antibiotics has your child had in their life? ______________________

Has your child taken any other prescription medications in their life? ______________________

Currect prescriptions: ______________________