PEDIATRIC INTAKE & HISTORY FORM

Welcome! Please thoroughly complete all questions. Thank you.

PATIENT INFORMATION

Patient Name: _____ Today's Date: _____

Birth date: _____/_____/_____ Age: _____ Sex: M / F

Address: _____

City/State/Zip: _____

Parent's Name: _____ Relationship: _____

Parent's Phone: (Cell) _____

Parent's Email: _____

Parent's Occupation: _____Navy? How long are you stationed here?_____

Pediatrician Name: _____ Office: _____

Contact Number for Emergencies: _____

Who may we thank for referring you? _____

HOW CAN WE HELP YOUR CHILD?

Wellness Checkup ___ Other: _____

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

_____

_____

Health Goals for your child:

_____

_____

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)

___ Back/Other Pain ___ Gestational Diabetes ___ Pre-Eclampsia ___ Strep B

___ Nausea/Vomiting Pre-Term ___ Fatigue ___ Swelling

___ Other (please describe): _____

BIRTH HISTORY

Type of birth (check all that apply):

___ Hospital ___ Birth Center ___ Home ___ Normal/Vaginal ___ Breech Cesarean

___ Scheduled/Induced ___ Epidural ___ Forceps/Vacuum

How long were you in labor? _____ How long were you pushing? _____

Problems during labor/delivery? ___ Yes ___ No

If yes, please describe: _____

_____

Birth complications/anomalies (check all that apply):

___ Antibiotics ___ Congenital Anomalies ___ Failure to Thrive ___ Jaundice

___ Meconium-Respiratory Distress ___ Extended Hospitalization

Birth Trauma? ___ Bruises ___ Cord around Neck ___ Stuck in canal ___ Fast/long___ Odd-shaped head

GROWTH & DEVELOPMENT

Infant feeding: ___ Breast ___ Bottle ___ Formula Mom's Diet: _____

Difficulty with lactation or latching? _____

Lip or Tongue Tie? _____

Number of hours of sleep each night: _____ Quality of sleep: _____

Position of sleep: _____

At what age did the child:

Respond to sound: _____ Crawl: _____ Hold head up: _____ Stand: _____

Sit unsupported: _____ Walk unsupported: _____

Screen Time: _____ Diet: _____

SLEEP PATTERNS & REFLUX

How many times does your child wake per night? _____

Does your child have difficulty falling asleep? ___ Yes ___ No

Does your child have difficulty staying asleep? ___ Yes ___ No

Does your child wake crying/distressed? ___ Yes ___ No

Does your child experience reflux or spitting up? ___ Yes ___ No

If yes, how many times per day? _____

Does it occur: ___ After feeding ___ Between feedings ___ During sleep ___ Anytime

Is your child on medication for reflux? ___ Yes ___ No

If yes, medication name: _____

CHILDHOOD DISEASES, ILLNESSES & VACCINATIONS

Has your child had (check all that apply):

___ Chicken Pox ___ Measles ___ Robiola ___ Mumps ___ Rubella

___ Pertussis/Whooping Cough

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

___ Allergies ___ Broken Bones ___ Diarrhea Issues ___ Hypertension

___ Orthopedic Problems ___ Anemia ___ Chronic Earaches ___ Constipation/Diarrhea

___ Juvenile/Paralysis ___ Rheumatoid Arthritis ___ Arm Problems

___ Colds/Flu Dizziness ___ Poor Appetite ___ Asthma ___ Colic ___ Fainting

___ Joint Problems ___ Ruptured/Hernias ___ Back Aches

___ Convulsions/Seizures ___ Headaches ___ Leg Problems ___ Sinus Trouble

___ Bed Wetting ___ Delayed Speech ___ Heart Trouble ___ Neck Problems

___ Tuberculosis ___ Behavioral Problems ___ Diabetes ___ Hyperactivity

___ Neuritis ___ Walking Problems

Have you vaccinated your child? ___ No ___ Yes ___ As Scheduled ___ Delayed Schedule

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: _____

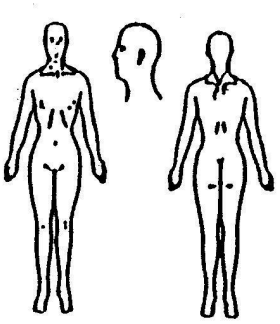
Are you currently pregnant? ___ Yes ___ No If yes, due date: _____

Children's health concerns: _____

Health concerns regarding this pregnancy? _____

CHIEF COMPLAINT #1

CIRCLE AREA(S) OF CONCERN:



Description of Complaint: _____

_____

When did this start? Was there a specific injury? _____

_____

What makes it better/worse?

Better: _____

Worse: _____

What type of pain/discomfort is it? (Circle all that apply)

Achy Sharp Dull Sore Pressure Pinch

Does it travel to other areas? Yes / No If yes, where? _____

Any numbness/tingling? _____

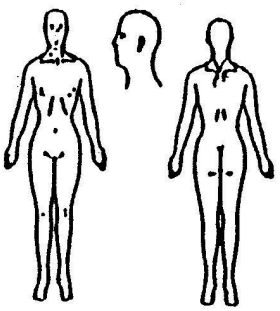
Out of 10: _____/10

How frequent does it occur?

Daily / Constant / Intermittent AM / PM Better / Worse

CHIEF COMPLAINT #2 (if applicable)

CIRCLE AREA(S) OF CONCERN:



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CARE GOALS

What are your goals for your child's chiropractic care?

_____

_____

_____

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. The above information is true and accurate to the best of my knowledge.

Signed: _____ Date: _____

Witnessed: _____ Date: _____