Pediatric Intake

Utopia FAMILY CHIROPRACTIC

Confidential Patient Information:

Child's Name:_____ Nickname: _____

Parent or Guardian Name(s):_____

Home Address: _____

City, State, Zip: _____

Mom's Cell Phone: _____ May we leave a message? ☐ Yes ☐ No

Dad's Cell Phone: _____ May we leave a message? ☐ Yes ☐ No

Parent's email: _____

Would you like to receive emails (special offers, upcoming events, newsletters, etc.) ☐ Yes ☐ No

Birthdate: _____ Age: _____Weight: _____ Height: _____

How did you hear about us? _____

Who is the primary care physician? _____

Date of last visit: _____ Reason for last visit: _____

Is your child receiving care from any other health professional? ☐ Yes ☐ No

- If yes, please name them and their specialty: _____

Please list any significant family medical history: _____

_____

Current Health Conditions:

What health concern(s) bring your child to be evaluated by a chiropractor? _____

_____

When did the symptoms first begin? _____

How did the problem start? ☐ Suddenly ☐ Gradually ☐ Post injury

Is the condition: ☐ Getting Worse ☐ Improving ☐ Intermittent ☐ Constant ☐ Unsure

Has your child ever received care for this condition before? ☐ Yes ☐ No

- If yes, please explain: _____

What makes the symptom(s) better? _____

What makes the symptom(s) worse: _____

What is this affecting that is **MOST** important in your child's **LIFE?** _____

Your Top Three Health Goals for Your Child:

1. _____
2. _____
3. _____

What would you like to gain from care?

☐ Resolve Existing Condition

☐ Overall Wellness

☐ Both

Have you ever visited a chiropractor before? ☐ Yes ☐ No If yes, list name or clinic name:_____

Pregnancy and Fertility History: Share with us about your pregnancy:

How would you describe your pregnancy? _____

Any Fertility issues? ☐ Yes ☐ No If yes, please explain: _____

Did mother exercise? ☐ Yes ☐ No If yes, please explain: _____

Did mother drink? ☐ Yes ☐ No If yes, how many per week? _____

Did mother smoke? ☐ Yes ☐ No If yes, how many per week? _____

Was mother ill? ☐ Yes ☐ No If yes, please explain: _____

Please explain any notable episodes of mental or physical stress during your pregnancy:_____

_____

Is there anything else I should know about your pregnancy? _____

_____

Labor and Delivery History:

Child's birth was: ☐ Natural Vaginal birth ☐ Scheduled C-section ☐ Emergency C-section

Child's birth was: ☐ At home ☐ At a birthing center ☐ At a hospital ☐ Other: _____

Baby was born at _____ weeks gestation. Were you able to hold baby after birth? ☐ Yes ☐ No

How long were you in labor for? _____

How long did you push for (if applicable)? _____

If scheduled C-section did you ever go into labor? ☐ Yes ☐ No

Please check any applicable interventions or complication at birth:

☐ Breech ☐ Induction ☐ Pain meds ☐ Epidural ☐ Vacuum extraction ☐ Forceps

Other: _____

Please describe anything else you feel I need to know about labor and delivery: _____

_____

Child's birth weight: ____ Child's birth height: _____ APGAR score at birth: ____ APGAR score after 5 min: _____

Growth and Development History:

Is/was your child breastfed? ☐ Yes ☐ No If yes, how long: _____Difficulty with breastfeeding? ☐ Yes ☐ No

Was formula introduced? ☐ Yes ☐ No If yes, what age: _____

Did/does your child ever suffer from colic, reflux, or constipation as an infant? ☐ Yes ☐ No

If yes, please explain: _____

Did/does your child frequently arch their neck/back, feel stiff, or bang their head? ☐ Yes ☐ No

If yes, please explain:_____

At what age did your child: Respond to sound _____ Follow an object _____

Hold head up _____ Vocalize _____ Sit alone _____ Teethe _____

Crawl _____ Walk _____Eat solid food: _____

Please list any food intolerances or allergies and when they began: _____

_____

Please list your child's hospitalization and surgical history, including the year: _____

_____

Please list any major injuries, accidents, falls, and/or fractures your child has sustained in his/her lifetime including year: _____

Have you chosen to vaccinate your child? ☐ No ☐ Yes, on a delayed or selective schedule ☐ Yes, on schedule

Reactions to vaccinations? ☐ None ☐ Fever ☐ Pain at injection site ☐ Diarrhea ☐ Vomiting ☐ Fatigue ☐ Excessive crying ☐ Seizures ☐ Developmental regression ☐ Other: _____

Has your child received any antibiotics? ☐ Yes ☐ No

If yes, please list how many times and reason: _____

Night terrors or difficulty sleeping? ☐ Yes ☐ No If yes, please explain: _____

How many hours per day does your child typically spend watching a TV, computer, tablet or phone? _____

How would you describe your child's diet? ☐ Mostly whole, organic ☐ Pretty average ☐ High processed foods

Do you think your child is developing normally for their age:

Physically: ☐ Yes ☐ No

Emotionally: ☐ Yes ☐ No

Intellectually: ☐ Yes ☐ No

Consent to Evaluation of a Minor Patient

I, _____(Parent or Legal Guardian), hereby grant consent for my child _____ (Print Name of Minor) to receive a chiropractic examination which may include discussing health history, spinal exam, physical examination, and orthopedic and neurological testing by Dr. Lindsey White, D.C. at Utopia Family Chiropractic. I understand that all examination findings will be communicated with me, prior to the commencement of care. I have provided accurate information regarding the health of the child, both past and present. The Doctor or staff at Utopia Family Chiropractic will not be held responsible for any omission or errors made in the completion of this paperwork.

_____ _____

Signature of Parent or Legal Guardian Date