

# Pediatric Intake Form

## Dear New Patient,

It is a pleasure to welcome you to the Chiropractic & Acupuncture Centre! To help us serve you better, please complete the following information. We look forward to working with you to build better health for your family.

Name \_\_\_\_\_ Date \_\_\_\_\_  Male  Female  
First Last

Address \_\_\_\_\_ City \_\_\_\_\_ Prov \_\_\_\_\_ Postal Code \_\_\_\_\_

Date of Birth \_\_\_\_\_ Home Phone# \_\_\_\_\_ Work Phone # \_\_\_\_\_  
YYYY MM DD

Name of Parents/Guardians \_\_\_\_\_

Have you previously received chiropractic care?  Yes  No  
Name of Chiropractor \_\_\_\_\_ Date of last visit \_\_\_\_\_

How did you hear about our office?  Yellow Pages  Newspaper  Internet  Sign  Other \_\_\_\_\_  
 Patient (Name) \_\_\_\_\_  Physician (name) \_\_\_\_\_

Reason for contacting us? \_\_\_\_\_

Have you seen anyone else for this condition  Yes  No

If yes, who did you see and when? \_\_\_\_\_

Other Health problems? \_\_\_\_\_

Name of Pediatrician \_\_\_\_\_ Date of last visit \_\_\_\_\_

Reason \_\_\_\_\_

Medications your child has taken or regularly takes: \_\_\_\_\_

Vaccination history \_\_\_\_\_

Check any of the following conditions your child has suffered from during the past 6 months

- |   |   |   |                                    |                                      |
|---|---|---|------------------------------------|--------------------------------------|
| <input type="checkbox"/> Ear infections   | <input type="checkbox"/> Scoliosis          | <input type="checkbox"/> Chronic colds    | <input type="checkbox"/> Headaches | <input type="checkbox"/> Seizures    |
| <input type="checkbox"/> Asthma/Allergies | <input type="checkbox"/> Digestive problems | <input type="checkbox"/> Recurring fevers | <input type="checkbox"/> Colic     | <input type="checkbox"/> Bed wetting |
| <input type="checkbox"/> Growing pains    | <input type="checkbox"/> Car Accident       |   |                                    |                                      |

## Prenatal History

Name of Obstetrician/Midwife \_\_\_\_\_

Complications during pregnancy?  Yes  No

List \_\_\_\_\_

Complications during *previous* pregnancies?  Yes  No

List \_\_\_\_\_

Medications during pregnancy/delivery?  Yes  No

List \_\_\_\_\_

Alcohol or tobacco use during pregnancy?  Yes  No

Location of birth:  Hospital  Home  Other \_\_\_\_\_

Birth Intervention:  Forceps  Vacuum Extraction  Breach  Caesarian Section: Emergency or planned?

Complications during delivery?  Yes  No

List \_\_\_\_\_

Genetic disorders or disabilities?  Yes  No

List \_\_\_\_\_

# Feeding History

Breast Fed: Yes No How long: \_\_\_\_\_

Formula Fed: Yes No How long: \_\_\_\_\_

Introduced to solids at: \_\_\_\_\_ months

Introduced to cow's milk at \_\_\_\_\_ months

Food/juice allergies or intolerance Yes No

List: \_\_\_\_\_

# Developmental History

At what age (approximately) was your child able to:

Respond to sound: \_\_\_\_\_

Respond to visual stimuli \_\_\_\_\_

Hold Head up: \_\_\_\_\_

Sit up: \_\_\_\_\_

Crawl: \_\_\_\_\_

Stand Alone: \_\_\_\_\_

Walk Alone: \_\_\_\_\_

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (ie. bed, change table, stairs, etc). Was this the case with your child? Yes No

Is/has your child been involved in any high impact or contact type sports (ie. soccer, football, gymnastics, baseball, hockey, martial arts, etc.) Yes No

List: \_\_\_\_\_

Has your child ever been involved in a car accident? Yes No

List: \_\_\_\_\_

Has your child been seen on an emergency basis (fever, trauma, etc)? Yes No

List: \_\_\_\_\_

Was surgery required? Yes No

List: \_\_\_\_\_

# Childhood Diseases

Chicken Pox: Yes No Age\_\_\_\_\_

Rubella: Yes No Age\_\_\_\_\_

Whooping Cough: Yes No Age\_\_\_\_\_

Mumps: Yes No Age\_\_\_\_\_

Rubeola: Yes No Age\_\_\_\_\_

Other: Yes No Age\_\_\_\_\_