HERRMANN FAMILY CHIROPRACTIC

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Pediatric Intake Form

Patient Information:

Name:_____ Date: _____/_____/_____
First Middle Last

Preferred Name:_____ Date of Birth _____/_____/_____ Gender ☐ M ☐ F

Cell (_____)_____-_____ Home/Other (_____)_____-_____Email:_____

Address:_____
Street City State Zip

Parent(s)/Guardian(s) Name(s):_____

Emergency Contact:_____ Relation:_____ Phone (_____)_____-_____

School Information: School Name:_____ Grade/Level:_____

Current Sports & Extra Curricular Activities: _____

_____

Insurance Information (*complete if insurance card is not present at the first visit*):

Insurance Name:_____Member ID:_____ Group Number:_____

Name of Policy Holder:_____ Policy Holder Birthday ____/____/____

Relation to Holder:_____ Effective Date: ____/____/____ Policy Holder Phone: (_____)_____-_____

Policy Holder Address:(☐same as above)_____
Street City State Zip

Reason(s) for Visit:_____

Describe your child's symptoms: _____

_____

Describe incident/progression (if any):_____

When did this begin? ____/____/____ Since it started, has it gotten: ☐ better, ☐ worse, or ☐ stayed the same?

Has your child experienced this before? ☐No ☐Yes (explain)_____

_____

Have you sought care from another provider for this concern? ☐No ☐Yes (explain)_____

_____

Chiropractic Experience:

Has your child been adjusted by a chiropractor before? ☐Yes ☐No Date of last adjustment: ____/____/____

Chiropractor:_____ Location:_____

Chiropractor and/or office name City, State

How did you hear about our office? ☐Website ☐Facebook ☐Email ☐Drive/Walk by ☐Insurance Website

☐Family/Friend:_____☐Community Event: _____☐Other: _____

Child's Personal Health History (if known):

Child's birth was: Labor:_____ hours Pushing: _____ minutes

☐ at a hospital ☐ at a birthing center ☐ at home ☐ other:_____

☐ Natural vaginal (with no interventions)

☐ Vaginal with interventions (please select all that apply)

☐ Induction ☐ Pain medication ☐ Epidural ☐ Episiotomy ☐ Vacuum extraction ☐ Forceps

☐ C-section: ☐ Scheduled ☐ Emergency

Please explain any interventions/complications:_____

_____

Weeks Gestation: _____ Birth Wt:_____ Birth Ht: _____Current Wt: _____ Current Ht: _____

Was your child in the NICU? ☐ No ☐ Yes. Why and how long?_____

Please list any illnesses mother experienced while pregnant:_____

_____

Is/was your child breastfed? ☐ No ☐ Yes. How long?_____

Has your child received vaccinations? ☐ No ☐ Yes, some ☐ Yes, all required

Primary Care Physician:_____ Date of last physical: ____/____/____

Physician and/or office name

Office Phone: (_____)_____-_____ City, State:_____

Current Illnesses:_____

Previous illnesses:_____

Current medications: (Rx & OTC)_____

Supplements/Vitamins:_____

Personal Incident History (*include relative dates or ages*):

Surgeries ☐No ☐Yes (explain)_____

Broken Bones ☐No ☐Yes (explain)_____

Sprains/Strains ☐No ☐Yes (explain)_____

Hospitalizations ☐No ☐Yes (explain)_____

Auto Accident ☐No ☐Yes (explain)_____

Struck Unconscious ☐No ☐Yes (explain)_____

Other Injuries_____

Health Checklist (*mark all that apply, past and present*):

Musculoskeletal
- ☐ Ankle Pain/Injury
- ☐ Arthritis (Type:_____)
- ☐ Back Pain
- ☐ Cramps
- ☐ Disc Herniation
- ☐ Dislocation (Type:_____)
- ☐ Elbow Pain/Injury
- ☐ Joint Pain
- ☐ Knee Pain/Injury
- ☐ Muscle Pain
- ☐ Muscle Spasm
- ☐ Neck Pain
- ☐ Poor Posture
- ☐ Plantar Fasciitis
- ☐ Scoliosis/Spinal Curves
- ☐ Shoulder Pain/Injury
- ☐ Sprains/Strains
- ☐ TMJ Dysfunction/Syndrome
- ☐ Torticollis ("Wry Neck")
- ☐ Whiplash
- ☐ Wrist Pain/Injury

Neurological
- ☐ ADD
- ☐ ADHD
- ☐ Anxiety
- ☐ Autism Spectrum Disorder
- ☐ Cerebral Palsy
- ☐ Concussion/Head Injury
- ☐ Depression
- ☐ Epilepsy/Seizures
- ☐ Fibromyalgia
- ☐ Insomnia/Sleep Issues
- ☐ Loss of Balance
- ☐ Loss of Consciousness
- ☐ Loss of Hearing
- ☐ Loss of Memory
- ☐ Loss of Smell/Taste
- ☐ Loss of Vision
- ☐ Migraines/Headaches
- ☐ Multiple Sclerosis
- ☐ Nervous Tics
- ☐ Night Terrors
- ☐ Numbness (Location:_____)
- ☐ OCD
- ☐ Panic Attacks
- ☐ PTSD
- ☐ Sensory Processing Disorder
- ☐ Sleep Walking
- ☐ Speech Issues
- ☐ Tremors
- ☐ Vertigo/Dizziness

Head/Neck
- ☐ Cataracts
- ☐ Congestion
- ☐ Difficulty nursing/Painful latch
- ☐ Ear Infections
- ☐ Eye pain/Problems
- ☐ Frequent Colds
- ☐ Glasses/Contacts
- ☐ Hearing Aid
- ☐ Mouth Breathing
- ☐ Nosebleeds
- ☐ Plagiocephaly
- ☐ Sinus Infection
- ☐ Snoring
- ☐ Strep throat
- ☐ Strabismus ("Lazy Eye")
- ☐ Swollen Tonsils/Adenoids
- ☐ Tinnitus/Ear Ringing
- ☐ Tongue or lip tie

Heart/Lungs/Chest/Circulation
- ☐ Asthma
- ☐ Bronchitis
- ☐ CHF
- ☐ Cold Hands/Feet
- ☐ Congenital Heart Defect
- ☐ Irregular Heart Beat/Murmur
- ☐ Shortness of Breath
- ☐ Swelling of Ankles/Feet

Gastrointestinal
- ☐ Acid Reflux/Heartburn
- ☐ Celiac Disease
- ☐ Constipation
- ☐ Crohn's Disease
- ☐ Diarrhea
- ☐ Encopresis
- ☐ Food Sensitivities
- ☐ Gas Pain/Bloating
- ☐ Indigestion
- ☐ Irritable Bowel Syndrome
- ☐ Stomach Pains

Genitourinary
- ☐ Bedwetting
- ☐ Incontinence
- ☐ Irregular Menstrual Cycle
- ☐ Kidney Disease
- ☐ Kidney Infection
- ☐ Kidney Stones
- ☐ Painful Urination
- ☐ PMS/PMDD
- ☐ Urinary Frequency
- ☐ UTI

Skin
- ☐ Acne
- ☐ Cradle Cap
- ☐ Eczema
- ☐ Psoriasis
- ☐ Skin Sensitivity

Systemic/Constitutional
- ☐ Allergies
- ☐ Anemia
- ☐ Arteriosclerosis
- ☐ Autoimmune Disease
- ☐ Bleeding Disorder
- ☐ Bruise Easily
- ☐ Cancer (Type:_____)
- ☐ Crohn's Disease
- ☐ Colic
- ☐ Diabetes (Type:_____)
- ☐ Fatigue
- ☐ Hemorrhoids
- ☐ Hernia (Type:_____)
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ High Triglycerides
- ☐ Immune Deficiency
- ☐ Jaundice
- ☐ Muscular Dystrophy
- ☐ Thyroid Condition

Other:_____
_____
_____

Social History:

Exercise:	☐No ☐Yes, _____	Minutes	per	☐Day	☐Week	☐ Month
Fruits/Vegetables:	☐No ☐Yes, _____	Servings	per	☐Day	☐Week	☐ Month
Processed Foods:	☐No ☐Yes, _____	Servings	per	☐Day	☐Week	☐ Month
Restaurants:	☐No ☐Yes, _____	Meals	per	☐Day	☐Week	☐ Month
Soda/Pop:	☐No ☐Yes, _____	Servings	per	☐Day	☐Week	☐ Month
Water:	☐No ☐Yes, _____	Ounces	per	☐Day	☐Week	☐ Month

Family Health History (*include significant diseases and genetic disorders, if known*):			
	Condition(s)	Age	Alive or Deceased
Mother			☐ Alive ☐ Deceased
Father			☐ Alive ☐ Deceased
Sibling(s)			☐ Alive ☐ Deceased
Maternal Grandmother			☐ Alive ☐ Deceased
Maternal Grandfather			☐ Alive ☐ Deceased
Paternal Grandmother			☐ Alive ☐ Deceased
Paternal Grandfather			☐ Alive ☐ Deceased
Other			☐ Alive ☐ Deceased

Please provide any additional information about your child's health:

_____

_____

_____

I certify that I am the parent or legal guardian of the child listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to Herrmann Family Chiropractic. I authorize this office and its staff to examine and provide care for my child's condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by my child. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to my child will be charged to me, and I am responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and my child. I understand that fees for professional services will become immediately due upon suspension or termination of my child's care.

Printed name of parent/guardian:_____ Relation to patient:_____

Signature of parent/guardian: _____ Date:_____/_____/_____