

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			<input type="checkbox"/> Alive <input type="checkbox"/> Deceased
Father			<input type="checkbox"/> Alive <input type="checkbox"/> Deceased
Sibling(s)			<input type="checkbox"/> Alive <input type="checkbox"/> Deceased
Maternal Grandmother			<input type="checkbox"/> Alive <input type="checkbox"/> Deceased
Maternal Grandfather			<input type="checkbox"/> Alive <input type="checkbox"/> Deceased
Paternal Grandmother			<input type="checkbox"/> Alive <input type="checkbox"/> Deceased
Paternal Grandfather			<input type="checkbox"/> Alive <input type="checkbox"/> Deceased
Other			<input type="checkbox"/> Alive <input type="checkbox"/> 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: ____/____/____

