O'Hara Chiropractic
FREEDOM TO ENJOY LIFE
www.liveNwellness.com

Pediatric Intake Form (Birth to 12 years)

Patient Information:

Date: _____

Child's Name: _____ DOB: _____

Parents/Guardian's Name: _____

Home Phone #: _____ Cell Phone #: _____

Address: _____

E-mail Address: _____

Has your child been checked by a Doctor of Chiropractic? ☐ Yes ☐ No

If yes, please provide the name of the office & doctor: _____

Who is your medical pediatrician? _____

Reason for visit: ☐ Wellness ☐ Health Concern

Prenatal History:

Is your child adopted? ☐ Yes ☐ No

Did you have any complications and when? _____

Did you smoke? ☐ Yes ☐ No

Did you consume alcohol? ☐ Yes ☐ No

Did you take medication? ☐ Yes ☐ No

Any reason for the medication? _____

Birth History:

Did you have ultrasound during this pregnancy? ☐ Yes ☐ No

What was the frequency? _____

Place of Birth: ☐ Home ☐ Birthing Center ☐ Hospital

Provider: ☐ Midwife ☐ OB-Gyn ☐ Other

Type of Birth: ☐ Vaginal ☐ C-section

Were pain medications used? ☐ Yes ☐ No

Was labor induced? ☐ Yes ☐ No

If yes, why? _____

What position did you deliver in? ☐ Squatting ☐ On back ☐ Other

Birth Trauma? ☐ Doctor assisted ☐ Twisting/Pulling ☐ Vacuum Extraction ☐ Forceps

Newborn Trauma (medical procedures and tests):

APGAR score: birth___/10 5-minutes_____/10 ☐ Unsure

Did your child have a misshaped skull/head? ☐ Yes ☐ No

Were there purple markings on their face? ☐ Yes ☐ No

Did you breast feed your child? ☐ Yes ☐ No

Does your child prefer one breast over the other? ☐ Yes ☐ No

If yes, which side? ☐ Left ☐ Right

Does your child have any food allergies? ☐ Yes ☐ No

If yes, please list: _____

Has your child been immunized? ☐ Yes ☐ No

Reason for vaccination? ☐ Informed Decision ☐ Recommended ☐ I didn't know I had choice

Did your child have any negative reaction to the vaccines? ☐ Yes ☐ No

Were they reported? ☐ Yes ☐ No

Has your child ever had surgeries or visit to ER? ☐ Yes ☐ No

If yes, please elaborate: _____

Has your child been on antibiotics? ☐ Yes ☐ No
If yes, how often and what for? _____
Is your child currently taking any medications? ☐ Yes ☐ No
Is your child currently taking any vitamins? ☐ Yes ☐ No

Baby/ Toddler (0-4):

Have any of the following occurred?

☐ Fall from a changing table	☐ Frequent crying spells	☐ Fall out of a crib	☐ Sleeping Problem
☐ Play in a Johnny Jumper	☐ Involvement in MVA	☐ Frequent diarrhea	☐ Colic
☐ Repeated infections or or colds	☐ Fall off playground equipment	☐ Tumble down stairs	☐ Reaction to vaccines
☐ Ear infections	☐ Frequent fevers	☐ Constipation	☐ Tonsillitis

☐ (+ or -) weight gain ☐ Other (please explain): _____

Child (5-12):

Have any of the following occurred?

☐ Fall from a tree	☐ Fall off a bicycle	☐ Car accident	☐ Scoliosis
☐ Sports accidents	☐ Fall on playground	☐ Bed wetting	☐ Asthma
☐ Learning difficulties	☐ Hyperactivity/ Autism	☐ Stomach pains	☐ Allergies
☐ Leg/ Knee pains	☐ Other (please explain): _____		

What symptoms does your child complain of? _____
When did it begin? _____

Is it getting worse?	☐ Yes	☐ No	
Is the pain:	☐ Constant	☐ Intermit	☐ Cyclic
Effect on activity?	☐ Not at all	☐ Somewhat	☐ Always

Does the child participate in any of the following?

☐ Soccer	☐ Football	☐ Gymnastics	☐ Karate
☐ Hockey	☐ Lacrosse	☐ Basketball	☐ Dance
☐ Wrestling	☐ Baseball/Softball	☐ Volleyball	☐ Tennis
☐ Swimming	☐ Rugby	☐ Other: _____	

How would you rate your child's diet? ☐ Well Balanced ☐ Average ☐ High Sugar/ Processed Food
Does your child consume artificial sweeteners? ☐ Yes ☐ No
Number of hours your child sleeps? _____Hours per day
Sleep Quality? ☐ Good ☐ Fair ☐ Poor

Authorization to treat a Minor

I, _____ the undersigning parent/guardian having legal custody / guardianship of _____, a minor, do hereby authorize, request and direct Dr. O'Hara and whomever she may designate as assistant, to perform in judgement any examination and chiropractic diagnosis or treatment which is deemed necessary.

Any specific written authorization you provide may be revoked at any time by writing to us at the address provided on the front of this form.

Patient:_____ Signature: _____
Print Name *Parent/ Legal Guardian*