Elements Health CHIROPRACTIC INTAKE- CHILD

Must be filled out by parent/guardian.

Name: _____ Date of Birth: _____

Parent's Name: _____

Medical Doctor: _____ Last Visit to MD: _____

PREGNANCY

Did you carry to full term (40 weeks)? ☐ Yes ☐ No, _____ weeks

Did you take any medications during your pregnancy? ☐ No ☐ Yes, list: _____

Describe any complications and when they occurred: _____

DELIVERY

Delivery:
☐ Vaginal Birth ☐ Caesarean Section
☐ Medical Doctor/ Obstetrician ☐ Midwife
☐ Hospital Birth ☐ Home Birth

Other Information: ☐ Induction ☐ Epidural ☐ Forceps ☐ Vacuum Extraction

Describe any complications during delivery: _____

CHILDHOOD

Breastfed: ☐ Bottle Fed: ☐ Formula: _____

Any concerns with feeding: _____

Number of hours of sleep per night? _____ hrs Quality of Sleep: ☐ Good ☐ Fair ☐ Poor

List any current medications or supplements your child is taking: _____

List any previous medications, for what conditions, and how many times it was prescribed: _____

List any emergency/hospital visits: _____

As a baby/toddler (birth-4 years), did any of the following occur?

☐ Significant falls
☐ Tumble down stairs
☐ Colic
☐ Play in "Jolly Jumper"
☐ Frequent colds
☐ Bed wetting
☐ Frequent fevers
☐ Frequent bouts of diarrhea
☐ Did not gain weight
☐ Sleeping problems
☐ Frequent ear infections
☐ Constipation
☐ Reaction to vaccination
☐ Involved in a car accident
☐ Other: _____

As a young child (5-12 years), did any of the following occur?

☐ Significant falls
☐ Fall off bicycle
☐ Sports accident
☐ Car accident
☐ Frequent colds
☐ Bed wetting
☐ Hyperactivity
☐ Asthma
☐ Allergies
☐ Other: _____
☐ Learning difficulties
☐ Scoliosis
☐ Leg/knee pains
☐ Stomach pains

As a child or adolescent, has your child experienced any of the following?

☐ Headaches
☐ Dizziness
☐ Ringing in the ears
☐ Asthma
☐ Hyperactivity/ADHD
☐ Weight gain/loss
☐ Arm/wrist pain
☐ Neck/back pain
☐ Sleeping problems
☐ Allergies
☐ Stomach problems
☐ Other: _____
☐ Foot/ankle/knee pain
☐ Tingling in the arms/legs
☐ Shoulder pains
☐ Fatigue
☐ "Growing Pains"

REASON FOR VISIT

☐ Health and/or spinal checkup? ☐ Correction and/or prevention of existing problem?

If your child has symptoms or a complaint, briefly describe the problem here: _____

_____

How and when did this problem start: _____

How often does s/he feel pain: ☐ Constant ☐ Comes and Goes

What aggravates the problem/symptoms? _____

What relieves the problem/symptoms? _____

Please describe any treatments and/or tests done for this problem, and the results: _____

_____

Is there anything else you would like us know? _____