NATURALLY
CHIROPRACTIC

Pediatric Intake Form

Date:_____

Child's First Name:_____ M.I.:_____ Last Name: _____

Social Security Number: _____

Address: _____

City / State / Zip: _____

Birth Date: _____ Age: _____ Sex: M / F

Pediatrician's Name / Clinic: _____

Parent's Names: _____

Best Contact Phone: ( )_____ Cell Phone: ( )_____

Email: _____

Who can we thank for referring you, or how did you hear about us? _____

Reason for Seeking Care

What is your reason for seeking care?_____

When did this begin? _____

Are there any major injuries and/or surgeries we should know about?

_____

Is this condition affecting your child's quality of life? If so, please explain. (ie. sleeping, eating, happiness...)

_____

Has your child seen any other providers for this condition? (List all that apply)

_____

Has your child seen a chiropractor before? Yes / No

How long ago? _____ Clinic/Doctor's Name: _____

Prenatal History

1. Location of birth: Hospital Birthing Center Home Other:_____
2. Did any of the following happen during delivery:

__*C-section Delivery*	__*Doctor pulled or twisted baby*	__ *Labor was induced*
__*Epidural*	__*Forceps/Vacuum extraction*	__*Premature delivery*

3. Describe any complications experienced during delivery:

_____

4. During pregnancy, did you use any drugs, tobacco, alcohol, and/or medications? *If yes, please list:*

_____

5. Did you experience any illness while pregnant? Yes / No *Explain*_____

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6. Birth Weight: _____ Birth Length: _____

7. Did you breastfeed the baby? Yes/No *If yes, how long:* _____

8. At what age did you introduce: Solids:_____ Milk:_____ N/A

Lifestyle Habits

1. Does your child exercise daily?	Yes/No	*Not applicable*
2. Does your child drink soda?	Yes/No	*Not applicable*
3. Does your child have a positive self-esteem/self-image?	Yes/No	*Not applicable*
4. Does your child watch more than an hour of TV per day?	Yes/No	*Not applicable*
5. Does your child eat balanced meals?	Yes/No	*Not applicable*
6. Does your child play video games?	Yes/No	*Not applicable*
7. Does your child experience prolonged sadness?	Yes/No	*Explain:*_____
8. Does your child have difficulty sleeping?	Yes/No	*Explain:*_____

Current Health Status

1. The National Safety Council reports approximately 50% of children fall head first from a high place during their first year of life (bed, changing table, stairs, etc.). Was this the case for your child? Yes/No
   *Explain:*_____

2. Has your child ever been hospitalized or had surgery? Yes/No
   *Explain:*_____

3. Does your child have difficulty interacting with others? Yes/No
   *Explain:*_____

4. Have you noticed that your child is nervous, twitches, shakes, or exhibits rocking behavior? Yes/No
   *Explain:*_____

5. Has your child been involved in any high impact/contact sports (soccer, football, martial arts, cheerleading, etc.)? Yes/No
   Please list: _____

6. Are you aware of any food allergies of intolerance? Yes/No

7. Has your child been vaccinated? Yes/No

8. Please rate stress levels on a scale of 1-10 (10 being highest)

School:	1	2	3	4	5	6	7	8	9	10
Personal:	1	2	3	4	5	6	7	8	9	10

Health Concerns

- ☐ Anxiety
- ☐ Depression
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea/Vomiting
- ☐ Diabetes
- ☐ Bed Wetting
- ☐ Unusually Cranky/Fussy
- ☐ Frequent Sickness

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- ☐ ADD/ADHD
- ☐ Torticollis
- ☐ Detachment/Distant
- ☐ Sinus Troubles/Allergies
- ☐ Autism
- ☐ Irritability/Nervous
- ☐ Difficulty Sleeping
- ☐ Asthma
- ☐ Difficulty Latching
- ☐ Colic/Acid Reflux
- ☐ Back/Neck Pain
- ☐

- ☐ Decreased/limited range of motion
- ☐ Difficulty Gaining Weight
- ☐ Ear Infections - How many? ___
- ☐ Headaches
- ☐ Learning Disorders
- ☐ Other:_____
  _____
- ☐ Is there anything else regarding your child's current condition you feel the doctor should know?
  _____
  _____

Medications:

- ☐ Anxiety/Depression
- ☐ Asthma
- ☐ Pain Narcotics
- ☐ Migraine/Headache
- ☐ Acid Reflux
- ☐ ADD/ADHD
- ☐ Digestive
- ☐ Other:_____
  _____

Vitamins/Supplements:

- ☐ Multi-Vitamin
- ☐ Vitamin D3
- ☐ Fish Oil/Omega-3
- ☐ Probiotics
- ☐ Other:
  _____
  _____
  _____

Consent to Treat a Minor

I, (Parent/Guardian) _____, give *Dr. Suzanna El-Yazigi, Chiropractic Physician*, permission to examine and treat my child _____.

Minor date of birth: _____/_____/_____

Parent/Guardian Signature: _____ Date:_____

Witness Signature: _____