Pediatric Intake Form

Last name: ____________________________ First name: ____________________________ Middle Initial: __________

Date of Birth: _________________ Age: ___________ Sex: ___________ Height: ___________ Weight: ___________

Name(s) of Parent(s)/Guardian(s): ____

Address: _____________________________________ City: ______________________ State: _____ Zip: __________

Cell #: _________________________ Home #: _________________________ Work #: _________________________

Email: ____

Emergency Contact: ______________________________________ Phone #: _________________________________

How did you hear about us? ____

Has your child ever received chiropractic care? ☐ Yes ☐ No With whom? _______________________________

How long since your child's last chiropractic visit? ☐ Days ☐ Weeks ☐ Months ☐ Years

Current Condition

Current Symptoms: ____

How long has your child experienced symptoms? ____

What is the cause of your child's symptoms? ____

Other doctors seen for this condition? _________________ Treatments? __________________________________

Has your child had similar symptoms before? ☐ Yes ☐ No If yes, explain: _________________________________

What activities aggravate the symptoms? ____

What activities lessen the symptoms? ____

Are the symptoms worse during certain times of the day? ☐ Yes ☐ No If yes, when? ________________________

Does your child's symptoms interfere with their daily activities? ☐ Yes ☐ No If yes, how? __________________

Rate the intensity of your child's pain/symptoms (0=none, 10=severe)

At their worst: 0 1 2 3 4 5 6 7 8 9 10
At their best: 0 1 2 3 4 5 6 7 8 9 10
Currently: 0 1 2 3 4 5 6 7 8 9 10

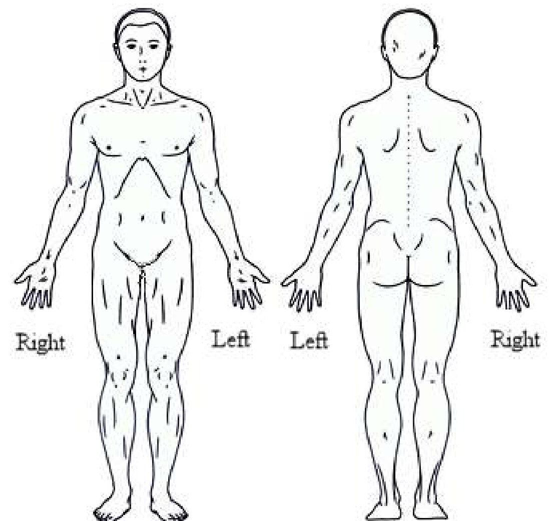
Are your child's symptoms getting progressively worse? ☐ Yes ☐ No

Check the description below that best describes the symptoms:
☐ Numb ☐ Achy ☐ Burning ☐ Sharp ☐ Throbbing

☐ Other: ____

How frequently does your child experience the symptoms?
☐ Constantly ☐ Frequently ☐ Occasionally ☐ Intermittently

Please circle the area(s) of the symptom(s) on the picture →



Health History: Please mark "C" for current and "P" for past for all that apply

___Dizziness	___Runny Nose	___Poor Memory	___Leg/Hip Pain
___ADHD	___Itchy Eyes	___Insomnia	___Knee/Foot Pain
___Back Pain	___Rashes	___Nightmares	___Growing pains
___Earaches	___Unusual Moles	___Bed Wetting	___Joint Pain
___Diabetes	___Sinus Trouble	___Pain Urinating	___Scoliosis
___Tuberculosis	___Cough/Wheeze	___Convulsions	___Blood disorders
___Hypertension	___Chest Pain	___Muscle Pain	___Stomach Aches
___Fever/Chills	___Constipation	___Fainting	___Other: _________
___Frequent Colds	___Anemia	___Broken bones	
___Arthritis	___Fever	___Sprains/Strains	
___Headaches	___Diarrhea	___Hernia	
___Asthma	___Poor Appetite	___Neck Pain	
___Allergies: _____	___Hyperactivity	___Arm/Elbow Pain	

Name of Pediatrician or Primary Care Physician: ____

Date of last visit: ____________________ Reason for last visit: ________________________________

Is your child currently being treated for any medical conditions? ☐ Yes ☐ No If yes, explain: ______________

____

Is your child currently taking any medications? ☐ Yes ☐ No If yes, what? ______________________

Is your child currently taking any supplements? ☐ Yes ☐ No If yes, what? ______________________

Has your child ever taken antibiotics? ☐ Yes ☐ No How many courses in his or her life? ____________

Has your child been injured participating in contact sports (football, hockey, martial arts, etc)? ☐ Yes ☐ No

If yes, describe (sprain, broken bone, head trauma, etc.) ____________________________________

Has your child ever been involved in a car accident? ☐ Yes ☐ No If yes, when? _________________

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (bed, changing table, stairs, etc.). Is this the case with your child?
☐ Yes ☐ No If yes, please explain: ____

Patient's Birth History (Please complete for patients 5 and under)

Type of Birth: ☐ Vaginal ☐ Forceps ☐ Vacuum ☐ Breech ☐ Caesarean-planned or emergency

Weeks gestation at birth: ______ Did the provider use his/her hands to assist delivery? ☐ Yes ☐ No ☐ Unknown

Any complications during delivery? ☐ Yes ☐ No If yes, explain: ____________________________

Patient's Feeding History (Please complete for patients 5 and under)

Breast fed? ☐ Yes ☐ No How long? ______________ Formula fed? ☐ Yes ☐ No How long? ______________

Did/does your child prefer one breast/side over the other? ☐ Yes ☐ No If yes, which side? ____________

Introduced to solid food at __________ months Cow's milk at _____________ months

Any food allergies or intolerances? ☐ Yes ☐ No If yes, please list: ___________________________

Developmental History

Has your child met all developmental landmarks on time based on their age? ☐ Yes ☐ No ☐ Unsure

Are you concerned about the possibility of developmental delays? ☐ Yes ☐ No ☐ Unsure

Cancellation Policy

Our commitment to excellence in patient care requires that we receive **24 hour notice** to cancel your appointment. Failure to give adequate cancellation notice will result in a $25 missed appointment charge.
________ **(Please Initial)** I have read and understand the cancellation policy.

HIPAA Policy

I have received or been given the opportunity to review the Notice of Privacy Practices for Parno Family Chiropractic, and understand the situations in which this practice may need to utilize or release my medical records. I understand that this office will properly maintain my records, and will use all due means to protect my privacy as outlined in the Notice of Privacy Practices.
________ **(Please Initial)** I have read and understand the HIPAA policy.

Minor Consent to Chiropractic Care

I certify that the information that I have supplied is correct and accurate to the best of my knowledge.
I hereby authorize Dr. Parno and her designated staff member(s) to administer chiropractic care or therapeutic treatment modalities as deemed necessary to my son/daughter.

Signature________________________________ Print Name________________________________ Date___________

Thank you for choosing Parno Family Chiropractic. We look forward to helping you achieve your health goals.