ATLAS
CHIROPRACTIC CARE

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# Pediatric Intake Form:

Child's Name: ________________________________________ Date: ______________________________
Address: ________________________________________ City: ___________ State:_______ Zip:__________
Sex: Male Female Date of Birth: _______________ Age: _____ Height: _______ Weight: ____________
Name of Parents/Guardians: _________________________________ Email: _____________________
Home Phone: _________________ Work Phone: ________________ Cell Phone: ___________________
Whom may we thank for your referral?: ___________________________________________________

## General Questions/ Prenatal History

Birthing Intervention: □Normal □Vaginal Forceps □Cesarean □Suction Cap □Vacuum
Is your child adopted? □Yes □No Problems during pregnancy: __________________________________________
Problems during labor/delivery: __________________________________________________________________
Immunization history: ________________________________________________________________________
Number of doses of antibiotics your child has taken: During the past 6 months _______ During his/her lifetime________
At what age, if ever, did this child suffer from the following childhood diseases**?** □Chickenpox______ □Mumps______
□Measles______ □Rubella______ □Rubeola______ □Whooping cough_______ □Other______________________

**Present Complaint(s)**:___________________________________________________________________
**When did this begin?**:________________________________ Was there an accident/injury involved? □Yes □No
**Has your child had any past treatment for this complaint**?: □Yes □No Describe:_________________________

## Has this child ever suffered from:

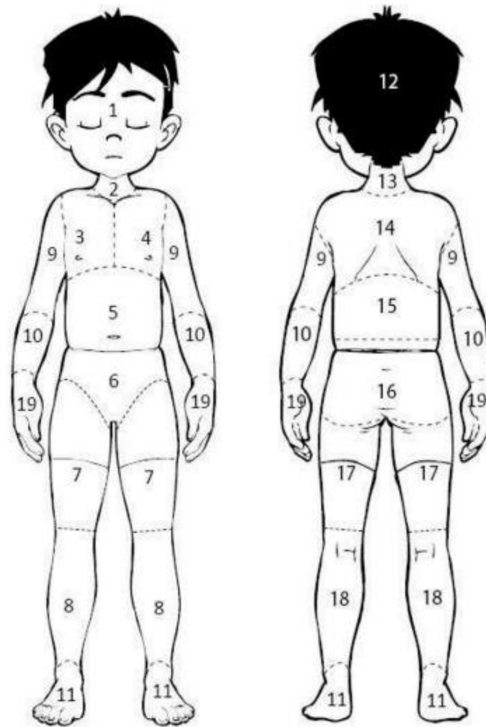
| | | | |
|---|---|---|---|
| □Headaches | □Orthopedic Problems | □Digestive Disorders | □Behavioral Problems |
| □Dizziness | □Neck Problems | □Poor Appetite | □ADD/ADHD |
| □Fainting | □Arm Problems | □Stomach Aches | □Ruptures/ Hernia |
| □Seizures/Convulsions | □Leg Problems | □Reflux | □Muscle Pain |
| □Heart Trouble | □Joint Problems | □Constipation | □Growing Pains |
| □Earaches | □Backaches | □Diarrhea | □Learning Difficulties |
| □Sinus Trouble | □Poor Posture | □Diabetes | □Sleeping Troubles |
| □Asthma | □Scoliosis | □Hypertension | □Torticollis |
| □Colds/Flu | □Walking Trouble | □Anemia | □Allergies:_________________ |
| □Colic | □Broken Bones | □Bed Wetting | □Other ___________________ |

**Has this child ever suffered from the following spinal traumas?**

| | | |
|---|---|---|
| □Fall in baby walker | □Fall from bed or couch | □Fall off skateboard or skates |
| □Fall from crib | □Fall off swing | □Fall off bicycle |
| □Fall from highchair | □Fall off slide | □Fall down stairs |
| □Fall from changing table | □Fall off monkey bars | □Other____________________ |

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e. bed, changing table, down stairs, etc.). *Was this the case with your child?* □Yes □No
Explain: ______________________________________________________________________

Has this child ever sustained an injury playing organized sports? If yes, please explain: ___________________________
______________________________________________________________________________
Has this child ever sustained injuries in an auto accident? If yes, please explain: _______________________________
Has this child ever broken/fractured any bones? Explain_____________________________________________________
Has this child ever received stiches not related to surgery:__________________________________________________
Other traumas not described above: ________________________________________________________________
Surgeries: ____________________________________________________________________________________
Medications: __________________________________________________________________________________
Present history: ________________________________________________________________________________
Purpose of this appointment: ____________________________________________________________________




**AUTHORIZATION FOR CARE FOR MINOR**

I hereby authorize this office and its doctor(s) to administer care as they so deem necessary to my son/daughter/ward (upon approval of guardian).

Signed: ______________________________Witnessed: ______________________________Date: ________________

I realize that I am responsible for all fees charged by this office and I agree to pay for all services provided. X-rays remain the property of this office. Signed: ______________________________ Date: _________________