ATLAS CHIROPRACTIC CARE
2322 Clover Street |Rochester, NY 14618
(585) 442-1500 | www.myatlaschiro.com

Pediatric Intake Form Patient (Child) Information:

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
□Chronic Earaches	□Backaches	□Diarrhea	□Learning Difficulties
□Sinus Trouble	□Poor Posture	□Diabetes	□Sleeping Troubles
□Asthma	□Scoliosis	□Hypertension	□Allergies:_____
□Colds/Flu	□Walking Trouble	□Anemia	□Other _____
□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: _____