



Pediatric Intake Form

Patient Information

Name _____ Date _____

Address _____

City _____ State _____ Zip _____

Phone Number _____

Date of Birth _____ Age _____ Gender M F

Mother's Name _____

Mother's Occupation _____

Mother's Phone _____

Mother's Email _____

In case of emergency, contact

Name _____

Relationship _____

Contact Number _____

Father's Name _____

Father's Occupation _____

Father's Phone _____

Father's Email _____

Who may we thank for referring you? _____

How can we help your child?

Wellness Checkup Other _____

If your child is already experiencing a symptom(s), please describe: _____

When did this symptom(s) appear? _____

Has your child been treated for this symptom(s) on an emergency basis? Yes No

Please describe: _____

Pregnancy History

Did mother experience any complications during her pregnancy? (check all that apply)

- Back / Other Pain Gestational Diabetes Pre/Eclampsia Strep B Nausea / Vomiting
 Pre-Term Fatigue Swelling Other (please describe) _____

Previous Chiropractic Care

Was the mother under chiropractic care during pregnancy? Yes No Last adjustment? _____

Has child had previous chiropractic care? Yes No Last adjustment? _____

Birth History

Type of Birth (check all that apply)

- Hospital Birth Center Home Normal/Vaginal Breech
 Cesarean Scheduled/Induced Epidural Forceps Vacuum Extraction

Problems during labor / delivery

- Antibiotics Congenital Anomalies Failure to Thrive Respiratory Distress Meconium
 Jaundice Extended Hospitalization Other _____

Growth and Development

Infant Feeding: Breast Bottle Formula

Number of hours of sleep each night: _____ Quality of sleep: _____

Has your child ever taken antibiotics? Yes No Condition treated: _____

Has your child ever been hospitalized? Yes No Condition treated: _____

At what age did the child:

Respond to sound _____ Crawl _____ Hold head up _____

Stand _____ Sit unsupported _____ Walk unsupported _____

Is this condition interfering with: School Sleep Concentration Daily Routine Other _____

Childhood Diseases, Illnesses, & Vaccinations

Has your child ever suffered from (check all that apply)?:

- | | | | | |
|--|---|--|--|---|
| <input type="checkbox"/> ADD/ ADHD | <input type="checkbox"/> Colds/ Flu | <input type="checkbox"/> Headaches | <input type="checkbox"/> Neuritis | <input type="checkbox"/> Head/Sports injuries |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Colic | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Orthopedic Problems | <input type="checkbox"/> Motor Vehicle Accident |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Convulsions/ Seizures | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Broken Bones |
| <input type="checkbox"/> Arm Problems | <input type="checkbox"/> Delayed Speech | <input type="checkbox"/> Dark circles under eyes | <input type="checkbox"/> Jaw/TMJ Problems | <input type="checkbox"/> Falls |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Paralysis | <input type="checkbox"/> Ruptures/ hernias | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Back Aches | <input type="checkbox"/> Stomach Aches | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Sinus Trouble | |
| <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Paralysis | <input type="checkbox"/> Runny Nose | <input type="checkbox"/> Rashes | |
| <input type="checkbox"/> Behavioral Problems | <input type="checkbox"/> Digestive Issues (constipation / diarrhea) | <input type="checkbox"/> Joint Problems | <input type="checkbox"/> Walking Problems | |
| <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Leg Problems | | |
| <input type="checkbox"/> Chronic Ear Aches/ Infections | <input type="checkbox"/> Fainting | <input type="checkbox"/> Neck Problems | | |

Have you vaccinated your child?

- Yes No As Scheduled Delayed Schedule

Allergies, Medications, Surgeries (Past and Present)

ALLERGIES (list)

MEDICATIONS / SUPPLEMENTS (list)

SURGERIES (list)

Authorization of Care of Minor

The statements made on this form are accurate to the best of my knowledge. I hereby authorize this clinic and its doctor(s) to administer care as they so deem necessary to my son/daughter/ward.

SIGNATURE

DATE