Pediatric Intake Form

1. Please enter your information.

First Name: _____ Middle Initials: _____ Last Name: _____ Date of Birth: _____

Gender:
○ Female ○ Male

Street Address: _____ Apt./Unit #: _____ City: _____

State: _____ Zip Code: _____ Parents Names: _____

Parent's Social Security Number- Please list which parent it belongs to.

_____

Mobile Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____

Preferred contact method:
○ Mobile Phone ○ Home Phone ○ Work Phone ○ Email

2. Primary Insurance

Primary Insurance Company _____ Member ID / Policy # _____ Group Number _____

Client Relationship to Insured
○ Self ○ Spouse ○ Child ○ Other

Insured Name _____ Insured Phone # _____ Insured Date of Birth _____ Insured Sex
○ Female ○ Male

Insured Street Address _____ Insured City _____ Insured State _____ Zip Code _____

3. Upload photos of insurance card.

4. Sibling's Names and Ages

_____

Family Doctor's Name

_____

Family Doctor's Address

_____

Has your child ever received Chiropractic care?
☐ Yes ☐ No

If yes, Who is your child previous Doctor of Chiropractic?

_____

The date of last visit?

The reason of last visit?

Other professionals seen for this condition?

Results with that treatment?

Please choose the reason for your child's visit:
☐ Crisis Management ☐ Prevention ☐ Wellness
☐ Maximizing normal growth and development
☐ Other

If other please explain:

5. Present Health Concerns

Major:

Minor:

When did this problem begin?

Is this problem:
☐ Occasional ☐ Frequent ☐ Constant
☐ Intermittent

Does this problem radiate?
☐ Yes ☐ No

If yes, where?

What makes this worse?

What makes this better?

Is this problem worse during a certain time of day?
☐ Yes ☐ No

If yes, when?

Does it interfere with the child's sleep?
☐ Yes ☐ No

Does it interfere with eating?
☐ Yes ☐ No

Does it interfere with the child's daily routine?
☐ Yes ☐ No

Is this becoming worse?
☐ Yes ☐ No

6. Symptoms:

Often seemingly unrelated symptoms can manifest as other health concerns. Please check if your child has had any of the following:

☐ Headaches ☐ Breast pain ☐ Dental Problem ☐ Depression ☐ Loss of Balance ☐ Loss of Concentration
☐ Ears Buzzing ☐ Pneumonia ☐ Upper back pain ☐ Loss of Smell ☐ Constipation ☐ Bloating/gas
☐ Numbness in leg(s) ☐ Chest pressure ☐ Weight Gain ☐ Fatigue ☐ Sore Throats ☐ Ear pain/infections
☐ Numbness in hand(s) ☐ Bronchitis ☐ Muscle Cramps ☐ Loss of Memory ☐ Allergies ☐ Radiating Pain
☐ Sleeping Problems ☐ Reduced Mobility ☐ Weight Loss ☐ Irritability ☐ Sinus Congestion ☐ Asthma
☐ Numbness in Feet ☐ Cold Sweats ☐ Heartburn ☐ Vision Changes ☐ Neck Pain ☐ Low back pain
☐ Light sensitivity ☐ Face Flushed ☐ Stiffness ☐ Dizziness ☐ Frequent Colds ☐ Fevers
☐ Heart Palpitations ☐ Fainting ☐ Weakness ☐ Poor Concentration ☐ Difficulty breathing
☐ Shortness of breath ☐ Loss of Taste ☐ Diarrhea ☐ Urinary Problems ☐ Other

If other, please explain:

7. Birth History

What was the child's gestational age at birth?

What was the child's birth weight? (pounds and ounces)

Was your child's birth?
☐ At home ☐ In a birthing center ☐ Hospital ☐ Other

If other please explain:

Was the birth considered?
☐ Medical ☐ Midwife

What was the duration of the birth?

Was the child born:
☐ Cephalis (head first) ☐ Breech (feet first)

Were there any complications?
☐ Yes ☐ No

If yes, please explain:

Assistances used during the delivery?
☐ Forceps ☐ Vacuum extraction ☐ C-section
☐ Episiotomy

Any evidence of birth trauma to the infant?
☐ Bruising ☐ Odd shaped head
☐ Stuck in birth canal
☐ Fast or excessively long birth
☐ Respiratory depression ☐ Cord around neck

Was labor?
☐ Spontaneous ☐ Induced

Were medications or epidural given to the mother during birth?
☐ Yes ☐ No

If yes, please explain:

If there is anything else we need to know about the birth do so here:

8. Growth and Development

Was the infant alert and responsive within 12 hours of delivery? If No, please explain:

What age did the child respond to sound?

What age did the child follow an object?

What age did the child hold up their head?

What age did the child vocalize?

What age did the child sit alone?

What age did the child teethe?

What age did the child crawl?

What age did the child walk?

How does your child sleep?
☐ Front ☐ Back ☐ Side

How many hours per day does the child sleep?

Do you consider your child's sleep pattern normal?
☐ Yes ☐ No

If no, please explain:

Has the child has any hospitalizations or surgeries? If Yes, please list along with their age at the time.

Has the child received any vaccinations? If Yes, please list along with their age at the time.

Please list current medications and supplements:

9. **Family Health History Please note any health problems (ie: cancer, hereditary conditions, diabetes, heart disease) that are present.**

Mothers Family

Fathers Family

Siblings

10. **Physical Stressors: Since problems that chiropractors look for and detect can be related to many types of stressors, the following information is also very important to us.**

Any traumas to the mother during pregnancy? If Yes, please explain:

Any falls from couches, beds, changing tables, etc.? If Yes, please explain:

Any traumas resulting in bruises, cuts, stitches, or fractures? If Yes, please explain:

Any sports played?

Is a school backpack used?
☐ Yes ☐ No

If yes, is the back pack?
☐ Heavy ☐ Light ☐ Rolling

Does the student also carry sports equipment or an instrument throughout the school day?

11. **Chemical Stressors:**

Was this child breast-fed
☐ Yes ☐ No

If yes, how long?

Formula was introduced at what age?

Which formula?

Introduction of cow's milk at what age?

Began solid foods at what age?

Types of solid foods?

Food or juice intolerances? If yes, which ones.

During the mothers pregnancy did the mother smoke?
☐ Yes ☐ No

If yes, how much?

Were there any other smokers in the home during the pregnancy?
☐ Yes ☐ No

Did the mother drink alcohol during the pregnancy?
☐ Yes ☐ No

If yes, how much?

Any illnesses during the pregnancy? If yes please describe

Any supplements taken during the pregnancy? If yes, please describe

Any drugs taken during pregnancy?
☐ Yes ☐ No

Any Ultrasounds? If yes, how many?

Any invasive procedures during pregnancy (ie amniocentesis, Chronorionic Villi Sampling etc)?
☐ Yes ☐ No

If yes please explain:

Are there any pets at home? If yes, please list:

Any antibiotics given? If yes what was the reason:

Is the diet organic?
☐ Yes ☐ No

Do you use 'green products' in your home for cleaning?
☐ Yes ☐ No

How often do they receive processed foods, white sugar, gluten (flour), dairy in their diet?
☐ Never ☐ On weekends ☐ A few times per week
☐ Daily ☐ Nearly each meal
☐ On special occasions

12. Psychosocial Stressors

Any difficulties with lactation? If yes, please explain:

Any problems with bonding? If yes, please explain:

Any behavioral problems? If yes, please explain:

Any inattention? If yes, please explain:

Any hyperactivity or restlessness? If yes,please explain:

Any compulsiveness? If yes, please explain:

Any difficulties at daycare or school? If yes, please explain:

Any challenges with learning deficiencies? If yes, please explain:

Any night terrors, sleep walking, difficulty sleeping? If yes, please explain:

Any prolonged temper tantrums or separation anxiety? If yes, please explain:

Is the child in daycare? If yes, what age did they begin?

Is there a nanny or a regular sitter during the day if both parents are at work?
☐ Yes ☐ No

Is the child homeschooled? If yes, By whom?

Average number of hours of television per week?

Average number of hours of video games per week?

Average number of hours of computer usage per week (including school work)?

Does your child have a cell phone?
☐ Yes ☐ No

If yes, how often do they text or use the phone?

Do you feel that your child's social and emotional development is normal for their age? If no, please explain:

Thank you for completing this form. If you have anything to add below, please add notes which can then be discussed with the doctor. If there are any other questions or concerns which you have please discuss with the doctor.