



HEALTH DIFFERENT
 CHIROPRACTIC
An Advanced Approach

Date _____

Pediatric Intake Form

Whom may we thank for referring you:

Last Name: _____ First: _____ Sex: M / F

Address: _____ City: _____ State: _____ Zip: _____ Date of Birth: _____

Age: _____

Email: _____ Phone: Cell _____ Home _____

Guardian's Name: _____ Guardian's Name: _____

Prior Chiropractic Care:

Doctor's Name: _____ Clinic Name: _____ Phone: _____

For how long: _____ Excellent Good Fair Poor _____

X-rays taken: yes no If so, when: _____ Results _____ What areas: _____

Medical Doctor: Achieve _____

Doctor's Name: _____ Clinic Name: _____ Phone: _____

Other Healthcare Providers:

Doctor's Name: _____ Profession: _____ Phone: _____

Doctor's Name: _____ Profession: _____ Phone: _____

Health Profile:

Why is this important?

As a family chiropractic office, we focus on your child's ability to be healthy.

Our goals are first to address the reason that brought you to this office, and second, to offer you and your child the opportunity of improved health potential and wellness service.

Reason for Visit:

The reason(s) that have prompted you to seek care for your child today: _____

When did you first start noticing this? _____ Cause? _____

How often does this occur? _____

Is this interfering with: School Sleep Walking Other _____

Other Doctors seen for this reason? _____

What over the counter medications, herbs, supplements, etc. is your child is taking? _____

Number of doses of antibiotics your child has taking? _____ Past 6 months _____

What prescriptions is your child is taking? _____ Reason _____ Past 6 months _____

Has your child had surgery? yes no What? _____

When? _____

How would you rate your child's overall health?

Worst he/she has ever been _____ Best he/she has ever been

Place an X on the line where you perceive they are overall.

Daily we experience physical, chemical, and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual and begin very early in life. Answering the following questions will give us information that will allow us to better assess the challenges to your child's health potential.

Pregnancy:

Were there any complications to the pregnancy? _____

Was Mom on any medications, prescription or over-the-counter yes no

If yes, explain: _____

Did Mom or Dad smoke during pregnancy? yes no Who? _____ Was the baby ever in the Breech position? yes no

How many ultrasounds were performed? _____

Birth and Delivery:

Where was the baby born?: Home Hospital Birthing Center Other _____

Was the delivery: Vaginal C-Section Were any devices used? Forceps Vacuum

How long was the labor? _____ How was the delivery? _____

Was oxytocin/pitocin used? yes no Was an epidural administered? yes no

Infancy:

Was the infant yes no Any adverse reactions? yes no If so, what? _____
Vaccinated? _____

Was there any prolonged use of medications or an inhaler? yes no If so, which _____

Did the infant suffer any traumas such as serious falls or car accidents? yes no

Childhood Years:

Did the child have any childhood illnesses? yes no Explain: _____

Does the child play youth sports? yes no Which sport(s): _____

Has the child fallen from a height over 3 ft.? yes no Explain: _____

Was the child involved in any car accidents? yes no Explain: _____

Has there been any prolonged use of meds? yes no Explain: _____

Has the child suffered emotional traumas? yes no Explain: _____

Please give us any other health information you feel would be helpful: _____

YOUR GOALS FOR YOUR CHILD'S CARE:

Feel better quickly/pain relief.

Feel better and prevent its return.

Have a healthier spine.

Optimum health and to live a healthier lifestyle.

We invite you to discuss with us any questions regarding our services. The best health services are based upon a friendly, mutual understanding between our team and yourself. Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with our office.

The statements made on this form are accurate to the best of my recollection and I request and give consent to this office to chiropractically examine and care for my child.

Parent's Signature _____ Date _____