PEDIATRIC CHIROPRACTIC INTAKE FORM

Date: _____ Please fill in or circle what applies

Patient (Child) Information: Name:
_____

Address:
_____

Sex (Circle): Male or Female Date of Birth: _____

Height at birth: _____ Current height: _____

Weight at birth: _____ Current weight: _____

Name of Parents/Guardian: _____

Cell Phone: _____ Work Phone: _____

Guardian Email:
_____

How did you hear about us:
_____

Is there a specific concern that brings you in?

Yes. Explain
_____

_____

_____

When did this begin?
_____

Was there an accident or injury involved? Y or N

Has your child had any past treatment for this complaint? Y or N

If yes, describe:
_____

Current medications/ Vitamins/Minerals:
_____

Was mother ill during pregnancy? Y or N

Did mother exercise during pregnancy? Y or N

Any complications during pregnancy? Y or N

If yes, explain:

_____

Birth Intervention (Circle): Forceps, Vacuum, C-Section, Epidural-injection

Complications during delivery? Y or N

If yes, explain:

_____

Place of birth _____

Mother's medications during birth _____

Genetic disorders or disabilities: _____

How many times has your child been prescribed antibiotics in the past 6 months?

Past 6 Months: _____ Total during lifetime: _____

Feeding History:

Breast Fed: Y or N How long: _____

Formula Fed: Y or N How long: _____

Introduced to Solids at _____ Months

Cow's milk at _____ Months

Food Allergies or Intolerances: Y or N

Did child ever suffer from (Circle): colic, reflux, or constipation?

Childhood Diseases: _____ Age: _____

Is/has your child been involved in any high-impact or contact type of sports (i.e.: soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.)? Y or N

Other traumas? Y or N If yes, explain:

_____

Prior surgeries? Y or N If yes, explain:

_____

Review of Systems Please check if your child has had any of the following: ____ Headaches ____ Postural Imbalances ____ Growing Pains ____ Scoliosis ____ Tonsillitis ____ Asthma ____ Torticollis ____ Ear Infections ____ Seizures ____ Sleep

Problems ____ Digestive Problems ____ Bedwetting ____ PDD/Autism ____ ADD/ ADHD ____ Frequent Fever ____ Colic ____ Learning Difficulties ____ Acid Reflux ____ Hip Dysplasia ____ Allergies Any behavioral, social or emotional issues? Y or N If yes, explain: _____

_____

_____

How many hours a day does your child typically spend watching TV, computer, tablet or phone? _____

How would you rate your child's diet (Circle): Well-Balanced, Average, High sugar/ processed foods

Number of hours your child sleeps: _____ hours per night _____hours per day/ naps

Sleep Quality (Circle): Good, Fair, Poor

What is your primary goal for your child at our clinic? _____

_____

_____

Authorization to Treat a Minor

I, _____, the undersigning parent/guardian having legal custody/guardianship of _____, a minor, do hereby authorize and request that the chiropractic specialists at Colonial Heights Chiropractic and Wellness, perform an examination and chiropractic diagnosis and/or treatment which is deemed necessary.

Patient's Name: _____

Signature of Patient's Parent/Guardian: _____

Date: _____