

Pediatric Intake Form

Child's Name: _____ Date: _____

Parents'/Guardians' Names: _____

Home Address: _____

Home Phone: _____ May we leave a message? Yes No

Parent's Cell Phone: _____ May we leave a message? Yes No

Parent's Work Phone: _____ May we leave a message? Yes No

Parent's Email: _____

How did you hear about us? _____

Height (of child): _____ Weight: _____ Birth Date: _____ Age: _____ Sex: _____

Siblings and ages: _____

Previous Chiropractic Care? Yes No

Emergency Contact

Name: _____ Relationship to child: _____

Phone number: _____ Alternative phone number: _____

Family Doctor

Name: _____ Professional Designation: _____

Clinic Name: _____ Date and reason of last visit: _____

May we communicate with your family doctor regarding your child's care if necessary? Yes No

Other Health Care Professionals

(Medical Specialist, Naturopathic Doctor, Homeopath, Physiotherapist, OT, Massage Therapist, etc)

Name: _____ Professional Designation: _____

Clinic Name: _____ Date and reason of last visit: _____

Name: _____ Professional Designation: _____

Clinic Name: _____ Date and reason of last visit: _____

Why have you decided to have your child evaluated by a Chiropractor?

- He / She is continuing ongoing care from another chiropractor.
- I recently had my spine checked and understand the value in getting my child checked.
- I have concerns about his/her health and I'm looking for answers.
- He / She has a specific condition and I've learned that chiropractic may be able to help.
- I want to improve my child's immune function.

Wellness Profile

The human body is designed to be healthy. The primary system in the body which coordinates health and function is the nervous system. Your nervous system is surrounded and protected by the bones of the spine, called *vertebrae*. Many of the common health challenges that adults experience have their origins during the *developmental years*, some starting at birth. Layers of damage to the spine and *nervous system* occur as a result of various *traumas, toxins, and emotional stress*. The result may be misalignment to the spinal column and damage to the nervous system - a condition called *Vertebral Subluxation*. Please answer the following questions to give us a better understanding about your child's state of wellness and factors which may be contributing to vertebral subluxation and impeding your child's *ability to heal*.

What signals has your child's body been communicating?

CURRENT	PREVIOUS		CURRENT	PREVIOUS		CURRENT	PREVIOUS	
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Failure to Thrive / Slow Weight Gain
<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Tract Infections	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Slow or Absent Reflexes
<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>	Flatulence	<input type="checkbox"/>	<input type="checkbox"/>	Asymmetrical Crawling or Gait
<input type="checkbox"/>	<input type="checkbox"/>	Ear Infections	<input type="checkbox"/>	<input type="checkbox"/>	Headaches/Migraines	<input type="checkbox"/>	<input type="checkbox"/>	Weight Challenges
<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	Bed Wetting
<input type="checkbox"/>	<input type="checkbox"/>	Strep Throat	<input type="checkbox"/>	<input type="checkbox"/>	Torticollis / Head Tilt	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Problems
<input type="checkbox"/>	<input type="checkbox"/>	Frequent Colds / Croup	<input type="checkbox"/>	<input type="checkbox"/>	Trouble Feeding on One Side	<input type="checkbox"/>	<input type="checkbox"/>	Night Terrors
<input type="checkbox"/>	<input type="checkbox"/>	Recurrent Fevers	<input type="checkbox"/>	<input type="checkbox"/>	Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Tip Toe Walking
<input type="checkbox"/>	<input type="checkbox"/>	Eczema	<input type="checkbox"/>	<input type="checkbox"/>	Growing Pains	<input type="checkbox"/>	<input type="checkbox"/>	Sensory Processing Issues
<input type="checkbox"/>	<input type="checkbox"/>	Rashes	<input type="checkbox"/>	<input type="checkbox"/>	Scoliosis	<input type="checkbox"/>	<input type="checkbox"/>	Seizures
<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Red, Swollen, Painful Joint	<input type="checkbox"/>	<input type="checkbox"/>	Tremors / Shaking
<input type="checkbox"/>	<input type="checkbox"/>	Food Sensitivities	<input type="checkbox"/>	<input type="checkbox"/>	Colic	<input type="checkbox"/>	<input type="checkbox"/>	ADD / ADHD
<input type="checkbox"/>	<input type="checkbox"/>	Digestive Problems	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Crying Spells	<input type="checkbox"/>	<input type="checkbox"/>	Autism / PPD

Do you have a specific concern that brings you in?

No, I would like my child's nervous system assessed to achieve optimal health & functioning.

Yes: _____

If yes, please answer the following questions:

Does your child appear to be in pain or discomfort? _____ For how long? _____

Is it getting better, worse, or staying the same? _____ Suddenly or gradually? _____

Have you seen other health professionals regarding this complaint?

No if Yes, whom? _____

What treatment did they use? _____

Has your child taken any medication for this complaint? No Yes: _____

Has your child ever experienced this complaint before? No Yes: _____

Has your child received any treatment at this time? No Yes: _____

Has your child had x-rays in relation to the current complaint? No Yes: _____

Has your child had any blood work done for the current complaint? No Yes: _____

Prenatal Profile

Adopted Prenatal history unknown Birth history unknown

Complications during pregnancy: No Yes (brief description): _____

Ultrasounds during pregnancy: No Yes (brief description): _____

Medications during pregnancy: No Yes (brief description): _____

If so which ones and how often? (include OTC): _____

Exposure to drugs, alcohol, cigarettes, or second hand smoke during pregnancy:

No Yes (brief description): _____

Birth Experience

Location of Birth: Home Hospital Birthing Center Other: _____

Birth Attendants: Doula Midwife GP OB Other: _____

Medications during labor / delivery (including IV antibiotics): No Yes: _____

Was Pitocin used to induce / speed up labor? No Yes

Were your membranes ruptured by a medical professional? No Yes

Was your child at anytime during your pregnancy in a constrained position? No Yes Unsure

If yes, please describe: Breech Transverse Face / Brow presentation

Was your delivery vaginal or C-section? _____ If C-section, was it planned or emergency? _____

If it was vaginal, was the baby presented: Head Face Breech

Were any of the following interventions used? Forceps Vacuum Extraction Other

Were there any complications during delivery? No Yes

If yes, please specify: _____

How long was the labor from the first regular contractions to the birth? _____ hours.

How long was the second stage (the pushing phase) of the labor? _____ hours.

Was the baby born with any purple markings / bruising on their face or head? No Yes

Any concerns about misshapen head at birth? No Yes

Post Natal & Infant History

How many weeks gestation was the baby at birth? _____ Weight: _____ Length: _____

If known, APGAR scores at: 1 minute: _____/10 5 minutes: _____/10

Was the baby ever administered to the NICU? No Yes

If yes, for how long and why? _____

Was any medication given to the child at birth? No Yes Unsure

If yes, what medication and why? _____

Was your child exclusively breastfed? No Yes Months: _____

Was your child breastfed + formula fed? No Yes Months: _____

Did your child show any sensitivities to formula (reflux, eczema, arching back)? No Yes

What age did you introduce solid foods to your child? _____ months

Did you introduce cereal or grains within your child's first year? No Yes

Did your child spend a lot of time in any baby devices (bouncy seats, swings, bumbos, car seats, etc)?

No Yes Which ones? _____

Physical Traumas

- Has your child ever fallen from any high places? No Yes _____
- Has your child ever been involved in a motor vehicle accident? No Yes _____
- Has your child been seen on an emergency basis? No Yes _____
- Has your child broken any bones? No Yes _____
- Has your child had any previous hospitalizations? No Yes _____
- Has your child had any previous surgeries? No Yes _____
- Does your child use a tablet, computer, or video game? Never Rarely Daily Several hrs/day
- Does your child watch TV? Never Rarely Daily Several hrs/day
- Does your child exercise? No Daily Weekly Seasonally
- Does your child play contact sports? No Daily Weekly Seasonally
- Does your child sleep on their... Back Belly Sides (both, right, left)
- Does your child carry a back pack? No Yes
- Does it weigh less than 15% of their body weight? No Yes
- Do they wear their back pack on 2 shoulders? No Yes
- Does your child show excessive or uneven shoe wearing out? No Yes
- Does your child wear custom orthotics?
 No Yes, For what purpose? _____

Chemical Stressors

- Have you chosen to vaccinate your child? No Yes, on a delayed schedule Yes, on schedule
- Reason for vaccination: Personal research Didn't know I had a choice It was recommended
- Reaction(s) to vaccination: None Fever Diarrhea Rash Welt at injection site
 Fatigue Seizures Prolonged Cry Developmental Regression
 Other: _____
- Does your child receive annual flu shots? No Yes (personal research) Yes (MD recommended)
- Has your child been exposed to antibiotics? No Yes
If yes, how many doses in past 6 months? _____ Reason: _____
- Has your child been exposed to medications, including OTC?
If yes, which ones? _____
If yes, how many doses in past 6 months? _____ Reason: _____
- How many glasses of water/day does your child have? 0 1-3 4-6 7-9 10+
- How many glasses of cow's milk, juice, and soda/day? 0 1-3 4-6 7-9 10+
- Does your child eat gluten? No Yes Trying to eliminate
- Does your child eat dairy? No Yes Trying to eliminate
- Any food/drink allergies or sensitivities? No Yes _____
- Is your child exposed to second hand smoke? No Yes _____
- Does your child take a probiotic daily? No Yes _____ CFU's/day
- Does your child take a vitamin D3 daily? No Yes _____ IU's/day
- Does your child take Omega 3 Fish Oils daily? No Yes _____ mg/day
- Other supplements or homeopathics? _____

Goals & Consent

Do you feel your child is developmentally appropriate for their age?

Intellectually: Yes No _____
Emotionally: Yes No _____
Physically: Yes No _____

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

Our goals are to provide a detailed assessment of your child’s current health status and provide to you the resources for a highly engaged and healthy child whose body is functioning at its absolute peak potential while they grow. Essential to this healthy growth is a nervous system functioning free from interference called subluxations. You’ve taken an important step for your child’s future through a chiropractic evaluation!

Consent to Evaluation of a Minor Child

I, _____, being the parent or legal guardian of _____,
(print name of consenting adult) (print name of minor)

hereby grant permission for my child to receive a chiropractic evaluation including history, spinal scan, and physical examination. Any findings will be communicated before consenting to commencement of treatment, if appropriate.

Consenting Adult’s Signature

Date