

Pediatric Intake

Infants and Toddlers

Patient Information

Child's Name: _____ Nickname: _____ Sex: M F
Birth Date: _____ Child's Height: _____ Child's Weight: _____
Parent/Guardian's Names: _____
Home Address: _____ City _____ State _____ Zip _____
Mom/Dad Cell Phone: _____ Mom/Dad Cell Phone: _____
Mom/Dad Email: _____
How did you hear about us? _____
Siblings and ages: _____
Previous Chiropractic Care? Yes No Doctor/Clinic: _____

Emergency Contact

Name: _____ Relationship to child: _____
Phone number: _____ Alternate number: _____

Family Doctor

Name: _____ Clinic Name: _____ Phone Number: _____
Professional Designation: _____ 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 Professional (Medical Specialist, Naturopath, Homeopath, Physiotherapist, Massage, etc.)

Name: _____ Clinic Name: _____ Phone Number: _____
Professional Designation: _____ Date and reason of last visit: _____

Name: _____ Clinic Name: _____ Phone Number: _____
Professional Designation: _____ Date and reason of last visit: _____

Why have you made the decision to have your child evaluated by a Chiropractor?

(check all that apply)

- He/She is continuing ongoing care from another chiropractor.
- I recently had my spine checked, and I understand the value in getting my child checked too.
- 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 in 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.

Which of the following has your child experienced?

CURRENT
PREVIOUS

- Asthma
- Respiratory Tract Infections
- Sinus Problems
- Ear Infections
- Tonsillitis
- Strep Throat
- Frequent Colds / Croup
- Recurrent Fevers
- Eczema
- Rashes
- Allergies
- Food Sensitivities
- Digestive Problems

CURRENT
PREVIOUS

- Frequent Diarrhea
- Constipation
- Flatulence
- Headaches / Migraines
- Neck Pain
- Torticollis / Head Tilt
- Trouble Feeding on One Side
- Back Pain
- Growing Pains
- Scoliosis
- Red, Swollen, Painful Joint(s)
- Colic
- Frequent Crying Spells

CURRENT
PREVIOUS

- Failure to Thrive / Slow Weight Gain
- Slow or Absent Reflexes
- Asymmetrical Crawling or Walking
- Weight Challenges
- Bed Wetting
- Sleep Problems
- Night Terrors
- Tip Toe Walking
- Regression of Milestones
- Seizures
- Tremors / Shaking
- ADD / ADHD
- Autism / PDD

Do you have a specific concern that brings you in?

- No, I'm interested in having my child's nervous system assessed for overall health and wellness.
- Yes: _____

If yes, please answer the following questions:

Does your child appear to be in pain or discomfort? _____ How long has your child been experiencing this? _____

Is it getting better, worse, or staying the same? _____ Was the onset sudden or gradual? _____

Have you seen other health professionals regarding this complaint? No 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: _____

Did he/she receive any treatment at the time? No Yes: _____

Has he/she had x-rays or imaging of this complaint? No Yes: _____

Prenatal Profile

Adopted Prenatal history unknown Birth History Unknown

Complications during pregnancy: No Yes: _____

Ultrasounds during pregnancy: No Yes: (how many?) _____

Medications during pregnancy: No Yes: _____

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

Exposure to alcohol, cigarettes, or second-hand smoke during pregnancy: No Yes: _____

Birth Experience

Location of Birth: Home Hospital Birthing Center Other _____
Birth Attendants: Doula Midwife GP OB/GYN 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 any time during your pregnancy unable to move? No Yes Unsure
If yes, please describe: Breech Transverse Face / Brow Presentation
Was your delivery... Vaginal C-section If it was a C-section, was it... Planned Emergency
If it was vaginal, was the baby presented... Head Face Breech
Were any of the following interventions used during delivery? Forceps Vacuum Extraction Other _____
Were there any complications during delivery? No Yes _____
How long was the labor from the first regular contractions to the birth? _____ Hours
How long was the 2nd stage (the pushing phase) of labor? _____ Hours
Was the baby born with any purple markings / bruising on his/her face or head? No Yes (where?) _____
Are/Were there concerns about a misshapen head at birth? No Yes

Post-Natal History

How many weeks gestation was the baby at birth? ___ weeks ___ days Birth Weight: ___ lbs ___ oz
If known, APGAR scores at: 1 minute ___ /10 5 minutes ___ /10 Birth Length: ___ inches
Was the baby ever admitted to the Neonatal Intensive Care Unit (NICU)? No Yes
If yes, for how long and why? _____
Was any medication given to the baby at birth? No Yes Unsure
If yes, what medication and why? _____

Child Health History (Answer only those which are applicable)

How many hours does your child sleep between feedings? _____ Hours during the day _____ Hours at night
Does your child have a preferred sleeping position? No Yes _____
Does your child have any feeding difficulties? No Yes _____
Is your child currently being breast fed? Yes, exclusively breast fed Yes, supplemented with formula No
If no, how long was the baby breastfed? _____ weeks / months My child was never breast fed
Does your child have a one-sided breast preference? No Yes (circle one) Left Right
Does your child frequently spit up after feeding? No Yes
If yes, how often? _____
Does your child cry often? No Yes How many hours per day? _____
Does your child pass a lot of intestinal gas? No Yes
Does your child frequently arch his/her head and neck backwards? No Yes
Has your child shown any sensitivities to foods either in the mother's diet or their own? No Yes
If yes, which foods? _____
Is your child exposed to cow's milk/dairy? No Yes, in formula Yes, drinking it Yes, I drink it and breast feed

Developmental History

	When?
Has your child ever fallen from a high place?.....	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
Has your child ever been involved in a motor vehicle accident or near miss?.....	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
Has your child been seen on an emergency basis?.....	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
Has your child broken any bones?.....	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
Has your child had any previous hospitalizations?.....	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
Has your child had any previous surgeries?.....	<input type="checkbox"/> No <input type="checkbox"/> Yes _____

Chemical Stressors

Have you chosen to vaccinate your child? No Yes, on a delayed or selective schedule Yes, on schedule

Reason for vaccination: Informed decision Didn't know I had a choice It was recommended

Reaction(s) to vaccination: Fever Welp at injection site Rash Diarrhea Fatigue Prolonged Cry
 Seizure(s) Developmental Regression Other _____

Does your child receive annual flu shots? No Yes, recommended by MD Yes, we chose to

Has your child been exposed to antibiotics? No Yes If yes, how many doses in the last 6 months? _____
Reason for antibiotic usage? _____

Were probiotics used at the same time as antibiotics? No Yes

Has your child been exposed to medications (including OTC)? No Yes If yes, which ones? _____
How many doses in the past 6 months? _____ Reason? _____

How many glasses of water per day does your child have?..... 0 1-3 4-6 7-9 10+

How many glasses of cow's milk, juice, and soda per day does your child have?..... 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

Does your child eat refined sugars (white sugar), white bread, and pasta?..... No Yes Trying to eliminate

Does your child eat boxed or frozen foods?..... No Yes Trying to eliminate

Do you feed your child organic foods? No Yes If yes, which: Meats Fruits Veggies Grains All

Does your child eat or drink any artificial sweeteners? No Yes _____

Does your child follow any other dietary restrictions? No Yes _____

Does your child have any food or drink allergies, sensitivities, or intolerances? No Yes

Is your child exposed to second-hand smoke? No Yes

Does your child take any supplements daily? No Yes

What amount(s) / brand(s)? _____

Goals and Consent

Do you feel your child is growing and developing appropriately for his/her age?

Intellectually: Yes No _____

Emotionally: Yes No _____

Physically: Yes No _____

What is your primary goal for your child regarding care 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 he/she grows. Essential to this healthy growth is a nervous system functioning free from interference called subluxations. You have taken an important step for your child's future through a chiropractic evaluation.

Consent to Evaluation of a Minor Child

I, _____, being the parent of 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 examination, and physical examination. Any findings will be communicated before commencement of treatment.

Consenting Adult's Name (printed)

Consenting Adult's Signature

Date

**Patient Acknowledgement and Receipt of
Notice of Privacy Practices Pursuant to HIPAA and Consent
for Use of Health Information**

Name _____
Print Patient's Name

Date _____

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant to HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersigned does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State Law and Federal Law.

Name _____
Patient's Signature

Date _____

If patient is a minor or under a guardianship order as defined by State Law:

By _____
Signature of Parent/Guardian (circle one)