Pediatric Intake

School-Aged Children

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		CURRENT	PREVIOUS		CURRENT	PREVIOUS	
☐	☐	Asthma	☐	☐	Frequent Diarrhea	☐	☐	Failure to Thrive / Slow Weight Gain
☐	☐	Respiratory Tract Infections	☐	☐	Constipation	☐	☐	Slow or Absent Reflexes
☐	☐	Sinus Problems	☐	☐	Flatulence	☐	☐	Asymmetrical Crawling or Walking
☐	☐	Ear Infections	☐	☐	Headaches / Migraines	☐	☐	Weight Challenges
☐	☐	Tonsilitis	☐	☐	Neck Pain	☐	☐	Bed Wetting
☐	☐	Strep Throat	☐	☐	Torticollis / Head Tilt	☐	☐	Sleep Problems
☐	☐	Frequent Colds / Croup	☐	☐	Trouble Feeding on One Side	☐	☐	Night Terrors
☐	☐	Recurrent Fevers	☐	☐	Back Pain	☐	☐	Tip Toe Walking
☐	☐	Eczema	☐	☐	Growing Pains	☐	☐	Regression of Milestones
☐	☐	Rashes	☐	☐	Scoliosis	☐	☐	Seizures
☐	☐	Allergies	☐	☐	Red, Swollen, Painful Joint(s)	☐	☐	Tremors / Shaking
☐	☐	Food Sensitivities	☐	☐	Colic	☐	☐	ADD / ADHD
☐	☐	Digestive Problems	☐	☐	Frequent Crying Spells	☐	☐	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 & Infant 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? _____
Was your child exclusively breastfed? ☐ No ☐ Yes How many months? _____
Was your child breastfed and formula fed? ☐ No ☐ Yes How many months? _____
Did your child show any sensitivities to formula (reflux, eczema, arching back, frequent spit up)? ☐ No ☐ Yes
What age did you introduce solid foods to your child? _____ months
Did/Do you practice attachment parenting methods: ☐ No ☐ Yes
(co-sleeping, kangaroo care, elimination communication, feeding on demand, extended breastfeeding, etc.)
Did your child spend excess time in any baby devices, such as: bouncer seats, swings, bumbos, car seats, etc.)?
☐ No ☐ Yes (which ones?) _____

Physical Traumas

When?

Has your child ever fallen from a high place?..... ☐ No ☐ Yes_____
Has your child ever been involved in a motor vehicle accident or near miss?..... ☐ 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 or surgeries?..... ☐ No ☐ Yes_____
Does your child spend time using a tablet, computer, or video games?..... ☐ 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 ☐ R Side ☐ L Side
Does your child carry a backpack..... ☐ No ☐ Yes
Does it weight less than 15% of their body weight?..... ☐ No ☐ Yes
Do they wear their back pack on 2 shoulders?..... ☐ No ☐ Yes ☐ Sometimes
Does your child show excessive or uneven shoe wearing out?..... ☐ No ☐ Yes (R or L?) _____
Does your child wear custom orthotics?..... ☐ No ☐ 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 ☐ Welt 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 you 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 privide 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 comencement 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 _____ Date _____

Print Patient's Name

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 _____ Date _____

Patient's Signature

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

By _____

Signature of Parent/Guardian (circle one)