Pediatric Intake Form

Patient Information

First Name:_____

Middle Name: _____

Last Name: _____

Gender: Female/ Male

Date of Birth:_____

Social Security #: _____

Height: _____

Weight::_____

Emergency Contact: _____

Relationship: _____

Number of Children: _____

Address Line 1: _____

Address Line 2: _____

City: _____

State/Province/Region:_____

*Zip/Postal Code:_____

Country: United States

Cell/Home Phone: :_____

Work Phone:_____

*Email: _____

(We will NOT share your email with any third party. We will only use your email to contact you in relation to your care with our practice.)

_____

Is there a history of any problems that the doctor should know about? Choose all that apply.

- [ ] No problems
- [ ] Epilepsy
- [ ] Acid reflux
- [ ] Febrile convulsions
- [ ] ADD
- [ ] Fever
- [ ] ADHD
- [ ] Foot flare
- [ ] Arm or shoulder condition
- [ ] Enuresis (bedwetting)

- [ ] Headache
- [ ] Hearing difficulties
- [ ] Inability to thrive
- [ ] Asperger's
- [ ] Autism
- [ ] Cerebral palsy
- [ ] Jaundice
- [ ] Sleeping problems
- [ ] Vision difficulties
- [ ] Colic
- [ ] Difficulty eating
- [ ] Down's syndrome
- [ ] Seizures
- [ ] Speech difficulties
- [ ] Torticollis
- [ ] Congenital anomalies
- [ ] Difficulty walking
- [ ] Ear infection (chronic)
- [ ] OTHER_____

How was the baby delivered?

Were forceps used in the delivery process?

( ) Yes ( ) No ( ) Uncertain

Was vacuum extraction used in the delivery process?

( ) Yes ( ) No ( ) Uncertain

How many hours was the labor?

How long was the pushing (in minutes)?

Was this a single or multiple birth?

What was the birth weight (pounds)?

What was the birth weight (ounces)?

What was the length of the child at birth (inches)?

What was the total APGAR score (5 minutes after birth, 10 is perfect)?

At how many weeks was the child born (gestational age in weeks)?

Physical Stressors

Were there any significant falls or traumas to the mother during the pregnancy?

Yes No Unsure

List any evidence of birth trauma:

- Bruising
- Respiratory depression
- Cord around neck
- Stuck in birth canal
- Fast or excessively slow birth
- Unknown/unsure
- None
- OTHER
- Odd-shaped head

Does the child have any history of serious falls or injuries, including fractures, concussions, hospitalizations, etc.?

Yes No Unsure

Does the child wear a backpack?

Does child participate in sports or exercise activities?

Does child engage in any hobbies or activities which require prolonged, awkward or repetitive postures (violin, gymnastics, ballet, etc.)?

Yes No Unsure OTHER

Chemical Stressors

As an infant, was the child breastfed?

Was formula introduced?

Was cow's milk introduced?

Have solid foods been introduced?

Does the child have any food, liquid or juice intolerances or allergies?

Yes No Unsure OTHER

During the pregnancy, did the mother smoke?

Yes No Unsure

During the pregnancy, did the mother drink alcohol?

Yes No Unsure

During the pregnancy, did the mother use recreational drugs?

Yes No Unsure

Did the mother suffer any illnesses during the pregnancy?

Yes No Unsure OTHER

Were any nutritional supplements prescribed or taken during the pregnancy?

Yes No Unsure

Were ultrasound(s) performed during the pregnancy?

Yes No Unsure

Were any invasive procedures performed during the pregnancy (Amniocentesis, Cerclage, etc.)?

Yes No Unsure

Are there any pets in the child's home?

Yes No Unsure

Are there any smokers in the child's home or environment?

Yes No Unsure

Has the child had any adverse reactions to vaccinations or medicines?

Yes No Unsure

Is there any history of antibiotics given to the child?

Yes No Unsure

Psychosocial Stressors

Have there been any difficulties with child-parent bonding?

Yes No Unsure

Does the child have any behavioral problems?

Yes No Unsure

Have any of the following behaviors occurred? Check all that apply.

- Attention issues
- Night terrors
- Bedwetting
- Sleepwalking
- Difficulty sleeping
- Stutter or stammer
- Failure to maintain eye contact

- [ ] Unsure
- [ ] OTHER
- [ ] Hearing issues
- [ ] Nervous tics

On average, how many hours per week of television does the child watch?

Do you feel the child's social and emotional development is normal for their age?

- ○ Yes
- ○ No
- ○ Unsure

Was there any delay in terms of the child's achievement of developmental goals? Choose all that apply.

- [ ] None, all developmental goals were met on schedule
- [ ] Delayed ability to walk
- [ ] Delayed response to sound
- [ ] Delayed ability to vocalize
- [ ] Delayed normal appearance of teeth
- [ ] Unsure
- [ ] Delayed ability to follow an object
- [ ] Delayed ability to sit alone
- [ ] Delayed ability to crawl
- [ ] OTHER
- [ ] Delayed ability to hold head up

Which vaccines has the child had to date? Choose all that apply. If all vaccination are up to date, select "Received all childhood vaccinations."

- [ ] Received all childhood vaccinations on schedule
- [ ] Pneunococcus (Prevnar)
- [ ] Was not vaccinated
- [ ] Hepatitis B (HBV)
- [ ] Diphteria (separate)
- [ ] Polio (OPV, IPV)
- [ ] Human Papillomavirus (HPV, Gardasil)
- [ ] Neisseria Meningitis
- [ ] DTP (Diphteria, Tetanus and Pertussis)
- [ ] Rubella (separate)
- [ ] Influenza (flu)
- [ ] Pertussis (separate)
- [ ] Haemophilus Influenza type B (HbCV)
- [ ] Tetanus (separate)

- [ ] Measles (separate)
- [ ] OTHER
- [ ] Varicella
- [ ] Mumps (separate)
- [ ] MMR (combination)

Authorization

I certify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

* [ ] I agree with this statement of authorization

Signature:_____