PEDIATRIC CHIROPRACTIC INTAKE FORM

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Patient (Child) Information

Name: _____ **Date:** _____

Address: _____

Sex M F DOB: _____ **Height:** _____ **Weight:** _____

SSN: _____ **Parent/ Guardian's Name(s):** _____

Contact Phone Number: _____ **Secondary Phone** _____

Did someone refer you to our office? Y N if so, who? _____

Birth Mother's Pregnancy

Did the mother have any injuries during pregnancy? (falls, accidents, etc): _____

_____

Any treatments required during pregnancy? (chiro, PT, etc) _____

_____

Any health problems during pregnancy? (gestational diabetes, pre-eclampsia, etc.) _____

_____

Please list any medications/supplements or drugs taken during pregnancy.

_____

Did you start prenatal vitamins prior to conceiving? Y N
If you started after you found out that you were pregnant, approximately what week gestation did you start your supplement? _____

Labor and Delivery

Type of Birth: Vaginal C-Section Forceps Vacuum Extraction Home Birth

Length of Labor: _____ **Was Labor Induced? Y N**

Delivered at how many weeks gestation: _____

Did mother have an epidural? Y N

Additional issues during or after delivery? _____

Did the delivery team do delayed cord clamping? Y N

Feeding History

Was your child breastfed Y N How long? _____

Was your child formula-fed Y N How Long? _____

When was your child introduced to:

Solid Foods? _____ months Cow's milk? _____ months

Food allergies or intolerances? Y N

If yes, please list:

_____

_____

Developmental History

Has your child missed any milestones or milestones that were delayed? Y N

At what month did your child rollover _____, sit on own _____, crawl _____, pull to stand _____, walk _____, say words _____

Does your child make eye contact? Y N

According to the National Safety Council, approximately 50% of children fall head-first from a high place during their first year of life. (i.e., a bed, changing table, lap, stairs, etc.)

Was this the case with your child? Y N

If yes, briefly explain

_____

_____

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

Child's System Review

Has your child received vaccinations? Y N

How would you rate your child's diet? (Circle one)

Well-Balance Average High in Sugars/Processed Foods

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

How would you rate your child's sleep? (Circle one) Good Fair Poor

General Symptoms

Please mark any symptoms the child is currently having or has had in the last year.

General	**Eye, Ear, Nose, and Throat**	☐ Diarrhea	**Skin**
☐ ADD/ADHD	☐ Pink eye	☐ Colitis/IBS	☐ Cradle Cap
☐ Allergies	☐ Vision issues	☐ Hernia	☐ Baby Acne
☐ Anxiety	☐ Crossed eyes	**Head, Neck, Spine**	☐ Eczema
☐ Autism/Asperger's	☐ Tinnitus	☐ Headaches	☐ Psoriasis
☐ Anemia	☐ Hearing loss	☐ Neck Pain/Stiffness	☐ Hives
☐ Bed Wetting	☐ Earaches	☐ Torticollis	☐ Rash
☐ Behavioral Issues	☐ Ear infection	☐ Mid Back Pain	☐ Bumps on skin
☐ Broken Bones	☐ Nose bleeds	☐ Low Back Pain	☐ Dark eye circles
☐ Cancer/Tumors	☐ Sinus Issues	☐ Back Spasms	**Childhood Illnesses**
☐ Depression	☐ Bad Breath	☐ Scoliosis	☐ Chicken Pox
☐ Diabetes	☐ Colds/Flu	☐Muscle/Joint Pain	☐ Colic
☐ Dizziness	☐ Runny Nose	**Arms and Hands**	☐ Croup
☐ Dyslexia	**Respiratory**	☐ Shoulder Pain	☐ Diphtheria
☐ Epilepsy	☐ Asthma	☐ Erb's Palsy	☐ Measles
☐ Fainting	☐ Bronchitis	☐ Little League Elbow	☐ Mumps
☐ Growing Pains	☐ Pneumonia	☐ Dislocation	☐ RSV
☐ Heart Problems	☐ Mononucleosis	☐ Numbness/Tingling	☐ Rubella
☐ Juvenile Arthritis	☐ Shortness of Breath	**Hips, Legs, Feet**	☐ Tetanus
☐ Nightmares	☐ Cough/Wheeze	☐ Joint Pain	☐ Whooping Cough
☐ Night Sweats	**Gastrointestinal**	☐ Hip Dysplasia	**Other**
☐ Paralysis	☐ Poor Appetite	☐ Toes pointed in/out	☐ _____
☐ Seizures	☐ Excessive Appetite	☐ Bow Legged	☐ _____
☐ Sensory Issues	☐ Bloating/Gas	☐ Knock-Kneed	☐ _____
☐ Speech Challenges	☐ Indigestion	☐ Walks on Toes	☐ _____
☐ Stroke	☐ Nausea	☐ Flat Footed	☐ _____
	☐ Reflux	☐ Limp	☐ _____
	☐ Constipation		☐ _____

Please use this area to elaborate on any symptoms marked on the previous page:

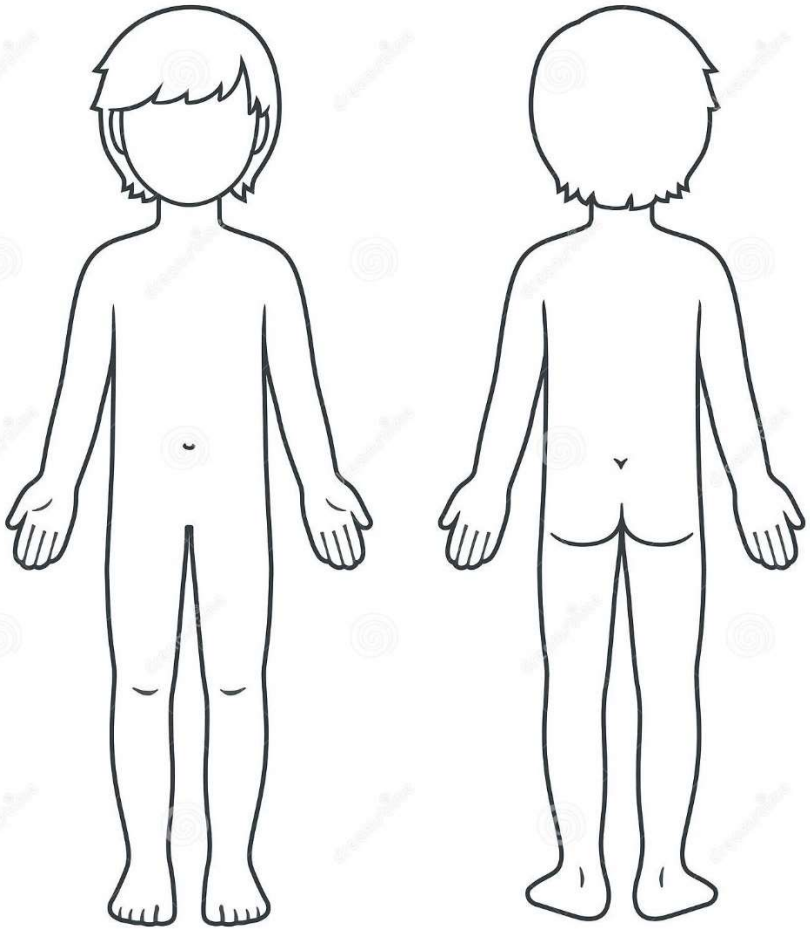
_____

_____

_____

_____

_____



Imagine this picture is your body. Please color in the area that is hurting you.

In your own words, what is your goal for your child with chiropractic care?

_____

_____

_____

_____

Authorization for Care of a Minor

I hereby authorize Corning Family Chiropractic and its provider to administer care they deem necessary to this child under my care. I accept responsibility for payment for services rendered.

The patient information given is true and complete to my knowledge.

Signature _____ Relationship to Child _____ Date _____

Authorization for Use of Photos

Corning Family Chiropractic (circle one) MAY MAY NOT use photos of this

child for uses not limited to Facebook, website, and other advertising purposes.

Signature _____ Relationship to Child _____ Date _____