PEDIATRIC INTAKE FORM

Patient Information

Child's Name: _____ Parent/Guardian Name: _____

DOB: _____ Age: _____ Sex: M F Street Address: _____

City: _____ State: _____ Zip: _____

Contact Numbers: Home: _____ Cell _____ Work _____

Height: _____ Weight: _____ Other children's names/ages: _____

How did you hear about us? : _____

Has your child been adjusted by a Chiropractor before? ☐ No ☐ Yes, reason for visits? _____

When was the last visit? _____

Is your child currently receiving care from other health professionals? ☐ No ☐ Yes If yes, list name and specialty

_____

Who is your Family Pediatrician/Primary Care Physician? _____

How did you hear about our office? ☐ Online Search ☐ Social Media ☐ Referral _____

HEALTH HISTORY

Describe the health concern(s) that prompted this visit: _____

_____

When did this concern begin? _____ How did this concern begin? _____

Has this condition: ☐ Worsened ☐ Stayed the same ☐ Been intermittent

Does this interfere with: ☐ School ☐ Sleep ☐ Daily Routine

What makes this condition worse? _____

What makes this condition better? _____

Has your child seen anyone else for this concern? YES NO Type of Treatment: _____

Please list any medications your child is currently taking + dosage (including OTC) : _____

_____

Doctor's Notes:

BIRTH INFORMATION

Child's birth was at: ▪ Home ▪ Birthing Center ▪ Hospital

OB/Midwife/Physician was: _____

Child birth was: **Natural vaginal with no medication**
Vaginal with interventions: Pitocin Epidural Pain Medications
Vacuum Extraction Forceps IV antibiotics
Other: _____

C-Section Scheduled Emergency

Adopted Prenatal history unknown Birth history unknown

Was your child at anytime during your pregnancy in a constrained position? YES NO UNSURE

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

Complications during pregnancy: YES NO (if yes, describe) _____

_____

Medications during pregnancy: YES NO (if yes, describe) _____

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

Exposure to drugs, alcohol, cigarettes, or second hand smoke during pregnancy: Yes No (If yes, describe) _____

_____

Birth Weight: _____lbs _____oz Birth Height: _____

TRAUMAS/ INJURY

Please list all hospitalizations and surgical history (include year) _____

_____

_____

Please list any major injuries, accidents, falls and/or fractures your child has sustained in his/her lifetime:

_____

_____

_____

What signals has your child's body been communicating?

Current	Previous		Current	Previous		Current	Previous	
☐	☐	Asthma	☐	☐	Frequent Diarrhea	☐	☐	Failure to Thrive
☐	☐	Respiratory Tract Infections	☐	☐	Constipation	☐	☐	Slow/Absent Refluxes
☐	☐	Sinus Problems	☐	☐	Flatulence	☐	☐	Asymmetrical Crawling/Gait
☐	☐	Ear Infections	☐	☐	Headaches/Migraines	☐	☐	Weight Challenges
☐	☐	Tonsillitis	☐	☐	Neck Pain	☐	☐	Bed Wetting
☐	☐	Strep Throat	☐	☐	Torticollis/Head Tilt	☐	☐	Sleeping Problems
☐	☐	Frequent Colds/Croup	☐	☐	Trouble Nursing	☐	☐	Night Terrors
☐	☐	Recurrent Fevers	☐	☐	Back Pain	☐	☐	Tip Toe Walking
☐	☐	Eczema	☐	☐	Growing Pains	☐	☐	Sensory Processing Issues
☐	☐	Rashes	☐	☐	Scoliosis	☐	☐	Seizures
☐	☐	Allergies	☐	☐	Red, Swollen, Painful Joints	☐	☐	Tremors/Shaking
☐	☐	Food Sensitivities	☐	☐	Colic	☐	☐	ADD/ADHD
☐	☐	Digestive Problems	☐	☐	Frequent Crying Spells	☐	☐	Autism

OTHER: _____

_____

What is your primary goal for your child at our office?

_____

_____

Our goal is provider a detailed assessment of your child's current health status and provide you with 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 properly functioning nervous system that is able to function free from interference called subluxation.

WRITTEN CONSENT FOR A CHILD

Name of patient (minor): _____

I authorize Dickinson Family Chiropractic to perform diagnostic procedures, chiropractic adjustments, and to render care to my minor/child. As of this date, I have the legal right to select and authorize health care services to my minor/child. If my authority to select and authorize is revoked or altered in any way, I will immediately notify Dickinson Family Chiropractic.

Date: _____ Guardian Signature: _____

Relationship to Minor: _____