PEDIATRIC CHIROPRACTIC INTAKE FORM

Date: ____

Patient (Child) Information:

Name: ____

Address: ____

Sex: Male ☐ Female ☐ Date of Birth: ____________ Height: __________ Weight: ___________

Patient SSN: _____________________ Name of Parents/Guardian: ___________________________

Home Phone: ________________ Cell Phone: ________________ Work Phone: ________________

Email: ____

How did you hear about us? ____

Authorized Representative/Parent/Guardian: _______________________ Phone: _______________

Is there a specific concern that brings you in?

☐ No, I would like my child's nervous system assessed to achieve optimal health and functioning.

☐ Yes. Explain ____

When did this begin? ____

Was there an accident or injury involved? Y N

Has your child had any past treatment for this complaint?

Y N Describe: ____

Current medications: ____

General Questions/Prenatal History:

Did mother smoke during pregnancy? Y N

Cigarettes or alcohol during pregnancy: Y N

Was mother ill during pregnancy? Y N

Did mother exercise during pregnancy? Y N

Any complications during pregnancy? Y N Explain: ____________________________________

Medications taken during pregnancy: ____

Birth Intervention: ☐ Forceps ☐ Vacuum ☐ C-Section

Complications during delivery? Y N Explain: ____

Place of birth ________________ Mother's medications during birth ________________________

Child's birth weight and height: __________________________________

Genetic disorders or disabilities: ____

How many times has your child been prescribed antibiotics in the past 6 months? _______________

Total during lifetime: _______________

Has your child received vaccinations? Y N Any adverse reactions? ________________________

Feeding History:

Breast Fed: Y N How long: __________
Formula Fed: Y N How long: __________
Introduced to Solids at _______ Months
Cow's milk at ________ Months
Food Allergies or Intolerances: Y N
Did child ever suffer from colic, reflux, or constipation? Y N

Childhood Diseases:

Chicken Pox:	Y	N	Age: _____________
Rubella:	Y	N	Age: _____________
Rubeola:	Y	N	Age: _____________
Mumps:	Y	N	Age: _____________
Whooping Cough:	Y	N	Age: _____________

Other: ____ Age: ______

Developmental History:

During the following times, your child's spine is the most vulnerable to stress and should routinely be checked by a Doctor of Chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference). At what age was your child able to do the following?

_______________ Respond to Sound
_______________ Respond to Visual Stimuli
_______________ Hold Head Up Alone
_______________ Sit Up Alone
_______________ Cross Crawl
_______________ Stand Alone
_______________ Walk Alone

Any childhood falls head first from a high place during their first year of life (i.e.: a bed, changing table, down stairs, etc.)? Y N Explain: ____

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

Has your child ever been involved in a car accident? Y N Explain: ___________________________

Other traumas not described above? Y N Explain: ____

Prior surgeries? Y N Explain: ____

Review of Systems

Please check if your child has had any of the following:

____ Headaches	____ Postural Imbalances	____ Growing Pains
____ Scoliosis	____ Tonsillitis	____ Asthma
____ Torticollis	____ Ear Infections	____ Seizures
____ Sleep Problems	____ Digestive Problems	____ Bedwetting
____ PDD/Autism	____ ADD/ADHD	____ Frequent Fever
____ Colic	____ Learning Difficulties	____ Acid Reflux
____ Hip Dysplasia	____ Allergies	

Any behavioral, social or emotional issues? ____

____

How many hours a day does your child typically spend watching TV, computer, tablet or phone? _____

How would you rate your child's diet? ☐ Well-Balanced ☐ Average ☐ High sugar/processed foods

Does your child consume artificial sweeteners? Y N

Number of hours your child sleeps: ________ hours per night ________hours per day/naps

Sleep Quality: ☐ Good ☐ Fair ☐ Poor

What is your primary goal for your child at our clinic? ______________________________________

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Authorization to Treat a Minor

I, ____________________________________, the undersigning parent/guardian having legal custody/guardianship of _____________________________________, a minor, do hereby authorize and request that Dr. Stahl perform an examination and chiropractic diagnosis or treatment which is deemed necessary.

Patient's Name: ____

Signature of Patient's Parent/Guardian: ________________________________ Date: ______________