ROCK SOLID CHIROPRACTIC

Acct#: _____

Pediatric Intake Form (up to 4 yrs)

Date:_____

Child's Name: (First Last)_____ **Sex:** Male/Female **D.O.B.:** ____/____/_____

Mother Name:_____**Cell #**:( )____-_____; **Father Name**:__ _____**Cell #:** ( )____-_____

Street Address:_____ **City**:_____**State** ____**Zip Code**: _____

Email: _____ **Text Appt. Reminders?**: ☐ Yes ☐ No *Send to Cell #*: ( )____-_____

Emergency Contact: _____Relation to Child: _____ Phone #: ( )____-_____

Insurance Information:

Ins. Company:_____ **Name of Subscriber:**_____ ☐ No Chiropractic Ins. Coverage/Self-Pay

Medical Healthcare Provider and/or Clinic Information:

Name of Clinic: _____ Dr./P.A.: _____ Phone#: (__)___-_____

Street Address:_____ City:_____ State _____ Zip Code: _____

When doctors work together it benefits you. May we have your permission to update your child's medical doctor regarding their care at this office? *(Please circle preference).* YES NO

Siblings in Household?:

Name: _____ Age:____ Sex: ____ / Name: _____ Age: ____ Sex: ____ / ☐ >3 siblings

Child's Health History:

What is your child's chief complaint today? *—Check all that apply—*

- ☐ Neck / Back / Joint pain
- ☐ Headaches
- ☐ Depression / Anxiety
- ☐ Respiratory Problems (e.g., asthma, allergies, sinus congestion)
- ☐ Digestive Problems (e.g., poor appetite, heartburn, constipation, diarrhea)
- ☐ Urinary Problems (e.g., difficult or painful urination, kidney stones)
- ☐ Fatigue or low energy
- ☐ Female reproductive health
- ☐ Male reproductive health
- ☐ Stress management
- ☐ General wellness
- ☐ Other(s): _____

Has your child ever had the same or a similar condition? _____ *If yes*, when and describe:_____

_____

How did it originally occur? *[If applicable, Date of injury :_____]* _____

Has it become any better/worse? *(Please circle)*. Gradually Better / No Change / Gradually Worse / Rapidly Worse

If yes, include when and how? _____

How frequent is the condition? *(Please Circle).* – Constant / Daily / Intermittent / A.M. or P.M. only *(circle one)*

How long does it last? *(Please Circle).* All Day Few Hours Minutes

Is there anything you can do to relieve the problem? *(Please Circle)* Yes No *If yes*, describe_____

_____

What have you tried so far that has *NOT* helped? _____

_____

Are there any other conditions or symptoms that may be related to your child's major symptom? *(Please Circle)*: Yes No

With an [N] or [P], please mark any health problems your child is experiencing Now or has in the Past—

___ Cancer (malignant or metastatic)
___Diabetes (Type I or II)
___Infectious Diseases (e.g. hepatitis, HIV)
___Heart, Lungs and Circulation (e.g. asthma, heart murmur)
___Digestive System (e.g. poor appetite, heartburn, constipation, diarrhea)
___Psychosocial Health (e.g. depression, anxiety,violence toward self or others)
___Skeleton and joints (e.g. arthritis, back or neck pain)
___Genitourinary System (e.g. UTI/bladder infection, kidneys,etc)
___Nervous System (e.g. headache, dizziness)
___Eyes, ears, nose, and throat (e.g. loss of vision or hearing, ear infections, severe dental problems)
___Skin (e.g. rashes, sores, moles that have changed)
___Chronic Immune System deficiencies (e.g. colds, sinusitis, bronchitis)
___Other: _____

. Acct#: _____ Date: _____

Family Health History:

Do/did any immediate family members have any major or congenital health conditions? *(Please Circle):* YES NO

If yes: Family member's relation to child: _____and their condition(s): _____

Pregnancy:

Please check any areas that applied to the patient's mother during her pregnancy:

- ☐ Complications
- ☐ Medications
- ☐ Recreational drugs
- ☐ Tobacco products
- ☐ Alcohol
- ☐ Caffeine: Cola/Chocolate
- ☐ Caffeine: Coffee/Tea
- ☐ Caffeine: Other
- ☐ Vitamins/Minerals
- ☐ Any diagnosed Illnesses
- ☐ Hospitalization
- ☐ Immunization
- ☐ Bleeding
- ☐ Premature Contractions
- ☐ Low Weight Gain or Weight Loss
- ☐ Excessive Weight Gain
- ☐ Toxic Exposures
- ☐ Allergic Reactions
- ☐ Mental Trauma
- ☐ Physical Injury
- ☐ New Back Pain
- ☐ Other New Pain
- ☐ Prenatal Classes/Care
- ☐ Chiropractic Care
- ☐ Carried to Full Term
- ☐ Attitude–More elevated than usual
- ☐ Attitude–More depressed than usual

Labor and Delivery

- ☐ Greater than 12 Hours
- ☐ Caesarian (Planned or ER?)
- ☐ Complications -Hospital or Home?
- ☐ Home Birth
- ☐ Medications/epidural
- ☐ Premature (Gave birth at ___wks)
- ☐ Forceps / Vacuum / Extraction (*Please Circle Applicable Method*)
- ☐ Other_____

Perinatal History – If known, please indicate:

Duration of pregnancy: _____weeks.
Birth Length: _____inches
Birth Weight: ___lbs._____oz.

APGAR score at birth:_____
APGAR score at five minutes:_____

Please check any *problems* the patient had at birth:

- ☐ Nursing/latching
- ☐ Coloring
- ☐ Sleeping
- ☐ Colic
- ☐ Jaundice
- ☐ Low Reflexes
- ☐ Meconium Aspiration
- ☐ Respiratory

Please check if any item(s) applied to your child at birth:

- ☐ Medication/Surgery
- ☐ Artificial Feeding
- ☐ Erythromyocin
- ☐ Vitamin K
- ☐ Circumcision
- ☐ Other(s):_____

Surgeries/Traumas/Injuries:_____

Allergies (To what + Reaction):_____

Current medications/dosages: _____

Nutrition

Please check the following items that your child has received:

- ☐ Breast Milk
- ☐ Commercial Formula
- ☐ Juice: Fruit
- ☐ Cow's Milk
- ☐ Goat's Milk
- ☐ Sweets
- ☐ Vegetable
- ☐ Solid Foods
- ☐ Medications
- ☐ Vitamins
- ☐ Other : _____

Immunizations

Please list any immunizations the patient has received along with the date it was received and any reactions observed:

_____

Additional space needed to complete intake form attached to form: ☐ Yes ☐ No

I,_____(Print Name), hereby declare all information regarding _____(Patient's Name). provided above is accurate, current and complete to the best of my knowledge.

Signature of Parent/Guardian: _____ Date_____