Community Chiropractic

Pediatric Intake

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| Demographic Information | First Name: | Last Name: | DOB |
| Mailing Address: |
| City | State | Zip |
| Parent / Guardian | Relationship |
| Primary Phone: Mobile? Y / N | Secondary |
| Email:  |

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| Health History | Purpose for Contacting Us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other Doctors Seen for this Condition: Y N Doctors' Names and Treatment(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Other Health Problems?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Check any of the following conditions your child has suffered from during the past six months: ❐ Ear infections ❐ Scoliosis ❐ Seizures ❐ Growing / Back pains ❐ Headaches ❐ Digestive problems ❐ ADHD ❐ Recurring fevers ❐ Chronic colds ❐ Colic ❐ Asthma / Allergies ❐ Bed wetting ❐ Car accident ❐ Temper tantrums Previous chiropractor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last visit: \_\_\_/\_\_\_/\_\_\_ Reason:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of pediatrician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last visit: \_\_\_/\_\_\_/\_\_\_ Reason:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Are you satisfied with the care your child receives there? Y N Number of doses of antibiotics your child has taken: During the past six months: \_\_\_\_\_\_\_ Lifetime:\_\_\_\_\_\_\_ List the antibiotics taken:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Vaccination history:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| Prenatal History | Name of Obstetrician/Midwife:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Complications during pregnancy? Y N \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ultrasounds during pregnancy? Y N Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medications during pregnancy/delivery? Y N List: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cigarette/Alcohol use during pregnancy? Y N Location of birth: ❐ Hospital ❐ Birthing center ❐ Home Birth intervention: ❐ Forceps ❐ Vacuum extraction ❐ Caesarian section ❐ Emergency or ❐ PlannedComplications during delivery? Y N List: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Genetic disorders or disabilities: Y N List: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth weight: \_\_\_\_\_\_\_\_\_\_ Birth length: \_\_\_\_\_\_\_\_\_\_\_ APGAR Scores: \_\_\_\_\_\_\_\_,\_\_\_\_\_\_\_\_ |

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| Feeding History | Breast fed: Y N How long: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Formula fed: Y N How long: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Introduced to solid foods at: \_\_\_\_\_\_\_\_\_\_\_ Months Cows’ milk at \_\_\_\_\_\_\_\_\_\_\_\_Months Food/Juice allergies or intolerances: Y N List\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| Developmental Hx | During the following times, your child’s spine is 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:***  \_\_\_\_\_Respond to stimuli (sounds & touching) \_\_\_\_\_Respond to visual stimuli \_\_\_\_\_Hold head up  \_\_\_\_\_Sit up \_\_\_\_\_Cross crawl \_\_\_\_\_Stand Alone \_\_\_\_\_ Walk alone According to the National Safety Council, approximately 50% of children fall headfirst from a high placeduring their first year of life (i.e. a bed, changing table, downstairs, etc.)Was this the case with your child? Y N Is / Has your child been involved in any high impact or contact sports (i.e. soccer, football, gymnastics, baseball, cheerleading, Martial arts, etc.)? Y N List: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Has your child ever been in a car accident? Y N List: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Has your child been seen on an emergency basis? Y N List: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Other traumas not described above? Y N List: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Prior surgery? Y N List:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Childhood diseases:** ❐ Chicken Pox, Age: \_\_\_\_ ❐ Rubella, Age: \_\_\_\_\_ ❐ Rubeola, Age: \_\_\_\_\_\_ ❐Mumps, Age: \_\_\_\_\_\_ ❐ Whooping Cough, Age: \_\_\_\_ ❐ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, Age: \_\_\_\_\_\_ |

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| Authorization for care of a Minor | I hereby authorize this office and its Doctors to administer care to my Son / Daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_ / \_\_\_\_\_\_ / \_\_\_\_\_\_**Insurance Permission**We need your permission with respect to the following two statements or we cannot make claims directly to your insurance company“I Authorize Community Chiropractic to release to my insurance company and medical or other information necessary to process my insurance claims.”“I authorize payment be made directly to Community Chiropractic. I permit a copy of this authorization to be used in place of the original”Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_ / \_\_\_\_\_\_ / \_\_\_\_\_\_ |