

Active Health Chiropractic

Pediatric Intake Form

Personal Information

Full Name: _____ Today's date: _____

Preferred Name: _____ Date of Birth: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Parents Names: _____ Contact Phone: _____

Pediatrician: _____ Phone: _____

Siblings Names: _____ Age: _____ Sex: _____

_____ Age: _____ Sex: _____

_____ Age: _____ Sex: _____

_____ Age: _____ Sex: _____

Who may we thank for referring you to our office?

Purpose of Care

Please answer all questions on behalf of your child if they are not old enough to fill out form on their own.

Is this visit the result of (please circle): auto injury wellness care other _____

What is/are the health condition(s) you are concerned with today?

*Major concern? _____

*Onset? _____

Is this condition (please circle): getting worse constant comes and goes

Is this condition interfering with your (please circle): school sleep daily routine.

Have you had this or similar conditions in the past? _____

Have you been treated by a Medical Doctor for this condition? _____

If so, where? _____ Results? _____

Have you ever had Chiropractic Care before? _____

If so, whom? _____ Results? _____

WELLNESS PROFILE - Chiropractic care affects more than just our muscles and bones. Please share with us what health goals you hope to find for this child. Circle as many goals as you wish.

- more energy better sleep freedom from pain better concentration

 easier breathing more balanced posture try quality vitamins
 improve nutrition improved coordination reduce medications
 improve overall health better sports performance enhanced emotional well-being
 greater resistance to disease other _____

Health History

Please explain any difficulties during pregnancy or labor: _____

The following occurred at delivery (please circle all that apply):

- Anesthesia Used Breech Presentation Emergency C-Section
 Face Presentation Forceps/Vacuum Induced labor Intensive care
 Planned C-Section Vaginal Delivery

During Infancy my child: Breast Fed _____ mos Bottle Fed _____ mos

My child is on the following vaccine schedule (please circle): standard alternative none

PERSONAL HEALTH HISTORY - Has this child ever suffered from:

- | | | |
|--|---|--|
| Major falls/injuries/fractures | Respiratory problems | Ear Infection |
| Allergy/Asthma | Bedwetting | Digestive problems |
| Medication: _____ | Hyperactivity | Hospitalization |
| Anxiety Disorders | Seizures | Extremity/ back pain |
| Gait problems | Antibiotic use | Other: _____ |
| <input type="radio"/> Dizziness/Fainting <input type="radio"/> | Heart trouble | Anemia/Blood Disorders <input type="radio"/> |
| Diabetes | Tuberculosis <input type="radio"/> | High blood pressure <input type="radio"/> |
| Arthritis | Headaches <input type="radio"/> | Growing Pains |
| Colic | <input type="radio"/> Sinus trouble <input type="radio"/> | <input type="radio"/> Orthopedic problems |
| <input type="radio"/> <input type="radio"/> | | |
| Poor appetite | <input type="radio"/> Behavioral problems <input type="radio"/> | |

My child has met all developmental milestones: Yes / No

Please list any other serious medical condition(s): _____

Allergies to foods or medications: _____

Surgeries: _____

Past Serious Accidents: _____

Please answer the following as completely as possible. Does your child:

Take supplements or vitamins? _____

Follow a special diet? _____

Carry a backpack (what style)? _____

Play Sports (which one(s))? _____

Watch TV (amount/day)? _____

Play Computer/Video Games (amt/day)? _____

FAMILY HEALTH HISTORY - Please circle the conditions below if someone in the child's immediate family has had the following. Please write how they are related to the child.

- | | |
|---|---|
| <input type="radio"/> Back Problems _____ | <input type="radio"/> Headaches _____ |
| <input type="radio"/> High blood pressure _____ | <input type="radio"/> Ulcer/Digestive Problem _____ |
| <input type="radio"/> Thyroid Disorder _____ | <input type="radio"/> Heart Disease _____ |
| <input type="radio"/> Stroke _____ | <input type="radio"/> Arthritis _____ |
| <input type="radio"/> Diabetes _____ | <input type="radio"/> Cancer _____ |
| <input type="radio"/> Osteoporosis _____ | <input type="radio"/> Mental Illness _____ |

Consent to Treat a Minor

I hereby authorize Active Health Chiropractic and its doctors to administer chiropractic 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.

Parent/Legal Guardian

Date

Witness

Date

