PEDIATRIC INTAKE AND HISTORY FORM

Please fill out this form completely and accurately as possible. All information requested below is necessary for us to serve your child with the best possible care.
Today's Date _____

ABOUT THE CHILD

Name _____ Male ___ Female___ Other _____

Date of Birth _____

Address _____ City _____

State _____ Zip _____

Phone Number _____

Parent/Legal Guardian Name(s) _____

Occupation/Employer _____

Email _____

Whom may we thank for referring you to our office? _____

PURPOSE OF VISIT/CURRENT CONCERNS

_____
_____
_____

Is the purpose of the visit related to any of the following?

☐ Tongue/Lip Tie ☐ Sensory Processing Difficulties
☐ Sports ☐ Auto ☐ Fall/Injury ☐ Chronic Discomfort

When did this condition begin?_____

Has this condition changed since onset?_____

Does this condition interfere with:

☐ Sleep ☐ Feeding ☐ Daily Routine ☐ School ☐ Other (explain)_____

Past/Current Treatment? (please include Doctor's name)

_____

Results of past/current treatments?

_____

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PRENATAL AND BIRTH HISTORY

Maternal Health

Yes ☐ No ☐ Is this your biological child? (If no, please answer the following for the biological mother if you have the information, otherwise go on to next section.)

Yes ☐ No ☐ History of miscarriages. If yes, how many?_____

Yes ☐ No ☐ Did you receive any vaccinations during the pregnancy?

Yes ☐ No ☐ Did you receive any flu shots during the pregnancy?

Yes ☐ No ☐ Diabetic

Yes ☐ No ☐ Thyroid Disfunction ☐ Hypothyroid ☐ Hyperthyroid

Mother's Occupation before and during pregnancy: _____

During pregnancy, did you use any: (all answers are kept strictly confidential)

☐ Street Drugs - Please List:_____ ☐ Alcohol ☐ Cigarettes

☐ Prescription Drugs – Please List:_____ ☐ SSRI (for depression/anxiety)

The Pregnancy

Yes ☐ No ☐ Any problems with the pregnancy? Please Describe:_____

☐ Bacterial infections ☐ Antibiotics ☐ Hospitalized during pregnancy ☐ Fertility drugs or IVF

Yes ☐ No ☐ Ultrasounds? How Many:_____
Yes ☐ No ☐ High Risk Procedures (cerclage, amniocentesis, bedrest)? Describe:_____
Yes ☐ No ☐ Supplements/Medication? List:_____

The Birth

☐ Vaginal ☐ C-Section ☐ VBAC ☐ Induced Weeks Gestation: _____

Medication used during labor and delivery: _____

How long was labor? _____ How long was pushing phase? _____

APGAR Scores: ☐Good ☐Poor

Birth Weight:_____ Length: _____

Complications during labor/delivery or concerns of birth trauma?

_____
_____
_____

NICU? _____ No _____ Yes How long? _____

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Infant and Toddler Years

Feeding History (check all that apply)

☐ Breastfed How long? _____

☐ Difficulty with latching ☐ Can't maintain latch ☐ Clicking ☐ Chewing/Chomping

☐ Pain with nursing ☐ Nipple damage ☐ Mastitis ☐ Poor supply

☐ Bottle-fed ☐ Formula (type)_____

☐ Colic ☐ Reflux On meds? Yes ☐ No ☐

☐ Difficulty Swallowing

Introduced solid foods? Yes ☐ No ☐ Known/Suspected Food sensitivities? Yes ☐ No ☐

Please List:_____

Milestones

Age	Milestone	Yes	No	Comments
6 weeks	Smiling	☐	☐	_____
3 months	Holds head up	☐	☐	_____
7 months	Sits unassisted	☐	☐	_____
9 months	Stands unassisted	☐	☐	_____
11 months	Crawling	☐	☐	_____
12 months	2-3 Words	☐	☐	_____
14 months	Walks unassisted	☐	☐	_____
16 months	Drinks from a cup	☐	☐	_____

Child's Health History

☐ vision problems	☐ pink eye	☐ headaches	☐ allergies
☐ hyperactivity	☐ constipation	☐ bedwetting	☐ frequent colds
☐ tubes in ears	☐ colic	☐ asthma	☐ irritability
☐ ear problems	☐ breathing problems	☐ digestive problems	☐ skin problems
☐ attention problems	☐ Other: _____		

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Please list any surgeries, procedures, broken bones, hospitalizations or if child is under care of a specialist:

_____
_____
_____
_____

Please list any current medications and supplements.

_____
_____
_____
_____
_____

Please check which of the following describes your child and vaccinations.

☐ I have chosen not to vaccinate my child.
☐ My child is partially vaccinated or is on a delayed schedule.
☐ My child is fully vaccinated on the medical vaccine schedule.
Any noted side effects or reactions?_____

Goals for My Child's Care
Children are seen by chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of the pain, and others for corrections of malfunctions in their bodies. Please check the type of care desired so that we may be guided by your wishes whenever possible.

☐RELIEF CARE – Symptomatic relief of pain or discomfort
☐CORRECTIVE CARE – Correcting and relieving the cause of the problem as well as the symptoms.
☐COMPREHENSIVE CARE – Bring whatever is malfunctioning in the body to the highest state of health possible with chiropractic care.

Please list specific goals for care (Examples: better sleep, reduced pain, wellness, ect.)

_____
_____
_____
_____
_____

Consent to Treatment of a Minor

I hereby request and authorize _____, and whomever he/she may designate as his/her assistant or authorized representative, to administer chiropractic care as he/she deems necessary to my dependent minor child. This authorization extends to include chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, diagnostic imaging, laboratory, and other testing at the doctor's discretion.

I certify that all information provided to this office is true and correct, to the best of my knowledge.

Child's Name _____ Relationship to Child _____

As of today's date, I have the legal right to select and authorize health care service for the minor child named above. If applicable, under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse, former spouse or other parent is not required. If my authority to select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

Name (print) _____ Name (signature) _____ Date: _____