PEDIATRIC INTAKE FORM

Doctor's Name: ____ Date: ________________

Doctor's Signature: ______________________________________PT ID #_______________

GENERAL INFORMATION

Patient Name:____ DOB: ________________ Age: _______ Gender:_______________

Name of Parents/Guardian: ____ Phone #: (___)______ - ______________

Home Address : ____ City, State, Zip: _____________________________________

PHYSICIAN INFORMATION

Pediatrician Name: ____

Date of and Reason for MOST RECENT pediatrician appointment: ____

Has your child been to a chiropractor before today? _______ Chiropractor Name: _______________________________________

PREGNANCY INFORMATION

Was the pregnancy high risk? _____ If yes, how so? ____

Did the mother experience any pains or illnesses during pregnancy? _____________ If yes, please explain: ____________________

____

BIRTH INFORMATION

Where was your child birthed? ____ Type of Birth: ☐ Vaginal ☐ C-Section

Birthing Assistance: ☐ Induction (Pitocin) ☐ Epidural ☐ Pain medication ☐ Forceps ☐ Vacuum Extraction

Weeks of gestation at birth: _________ Birth Weight: ________ Birth Height: _________ Initial APGAR Score: _______

Were there delivery complications? ________ If yes, please explain: ____

Was your child breastfed? _________ If yes, until what age? ____

PREVIOUS HEALTH HISTORY

Does your child have a disorder/disease? __________ If yes, please explain: ____

Has your child had surgery? ________ If yes, when and for what? ____

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INFANT/TODDLER (0-4 YEARS)

Have you noticed any of the following?

☐ Colic ☐ Loss of appetite ☐ Trouble sleeping ☐ Recurrent ear infections ☐ Recurrent colds

☐ Asthma/Allergies ☐ Constipation/Diarrhea ☐ Fever ☐ Unexpected weight gain or loss

If you are currently breast feeding, do you notice that the child has a preference for a particular breast? ______________________

If yes, which side does he/she prefer? ____________

Please describe any recent trauma (fails, hits on the head, car accidents) that your child has experienced:

____

____

At what age was your child able to:

Respond to sound __________ Sit up ____________ Respond to visual stimuli ____________

Hold head up ___________ Walk ____________

CHILD (5-12 YEARS)

Have you noticed any of the following:

☐ Fatigue ☐ Bed wetting ☐ Scoliosis ☐ Frequent Fever ☐ Asthma/Allergies ☐ Headaches ☐ Loss of appetite

☐Recurrent illnesses ☐ Unexpected weight gain/loss ☐ ADD/Hyperactivity ☐ Sinus troubles ☐Sleeping problems

☐Loss of Balance ☐ Light bothers eyes ☐Muscle spasms in the neck ☐ Dizziness ☐ Intestinal gas ☐ Stomach trouble

☐ Tonsil problems ☐ Nose bleeds ☐ Constipation/Diarrhea ☐ Irritability

What symptoms does your child complain of? ____

When did the symptoms begin? ________________ Are their symptoms getting better or worse? ___________________________

Are the symptoms constant or intermittent? ____________________ If intermittent, when? _______________________________

How have the symptoms been affecting your child's activity level? ☐ None ☐ Mildly ☐ Moderately ☐ Severely

Please describe any recent trauma (falls, hits to the head, car accidents) that your child has experienced:

____

____

Which sport does your child participate in?

☐ Soccer ☐ Lacrosse ☐ Basketball ☐ Karate/Martial Arts ☐ Swimming ☐ Baseball/Softball ☐Volleyball ☐ Dance

☐ Football/Rugby ☐Gymnastics ☐ Wrestling ☐ ____________________

For Female Patients

Has your child had her first period? ____________ If yes, at what age? ________

PARENT SIGNATURE: ____ **DATE**: ________________________