BULLER CHIROPRACTIC

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 (falls, 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**: _____