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Pediatric Chiropractic Intake Form - Ages 0-5 Years Old

Patient (Child) Information:

Name: Date:
Address:
Sex: Male Female Date of Birth: Height: Weight:
Name(s) of Parents/Guardian:
Home Phone: Cell Phone: Work Phone:
Email: Would you like our newsletter emailed to you: Y N
How did you hear about our office?

Present Complaint:

When did this begin? Was there an accident or injury involved? Y N
Has your child had any past treatment for this complaint? Y N Describe:
Current medications:

General Questions/Prenatal History:

Any complications during pregnancy? Y N Explain:
Medications taken during pregnancy: Cigarettes or alcohol during pregnancy: Y N
Birth Intervention: Forceps Vacuum C-Section (emergency / planned) Induction Epidural
Complications during delivery? Y N Explain:
Genetic disorders or disabilities:
How many times has your child been prescribed antibiotics in the past 6 months? Total during lifetime:
Has your child received vaccinations? Y N If yes, is it the full or graduated schedule?

Feeding History:

Breast Fed; How long:
Formula Fed; How long:
Introduced to:
Solids at Months
Cows milk at Months
Food Allergies or Intolerances: Y N
List:

Childhood Diseases:

Chicken Pox; Age
Rubella; Age
Mumps; Age
Whooping Cough; Age
Other: Age

Developmental History:

During the following times your child's spine is the 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 Sound Cross Crawl
Respond to Visual Stimuli Pulls up on Furniture
Hold Head Up Alone Stand Alone
Sit Up Alone Walk Alone

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (ie: a bed, changing table, down stairs, etc). Was this the case with your child? Y N
Explain:

Is/has your child been involved in any high impact or contact type of sports (ie: soccer, football, gymnastics, baseball, cheerleading, martial arts, etc)? Y N

Has your child ever been involved in a car accident? Y N Explain: _____

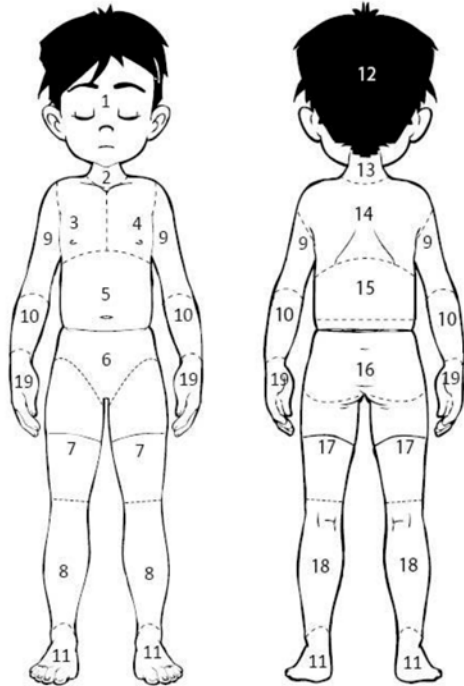
Other traumas not described above? Y N Explain: _____

Prior surgeries? Y N Explain: _____

DIET: How would you rate your child's diet? Well Balanced Average High sugar/processed foods

SLEEP: Number of hours your child sleeps: _____ hours per night _____ hours per day/naps

Sleep Quality: Good Fair Poor



- 1 – face
- 2 – neck
- 3 – left chest
- 4 – right chest
- 5 – stomach
- 6 – abdomen
- 7 – thighs
- 8 – legs
- 9 – upper arms
- 10 – lower arms
- 11 – feet
- 12 – back of head
- 13 – back of neck
- 14 – upper back
- 15 – middle back
- 16 – lower back
- 17 – back thighs
- 18 – back legs
- 19 – hands

Review of Systems

Please check if your child has had any of the following:

| | | |
|---------------------|----------------|-----------------------|
| Headaches | Ear Infections | ADD/ADHD |
| Postural Imbalances | Seizures | Frequent Fever |
| Growing Pains | Tonsillitis | Colic |
| Scoliosis | Sleep Problems | Learning Difficulties |
| Sensory Processing | Constipation | Acid Reflux |
| Asthma | Bedwetting | Hip Dysplasia |
| Torticollis | Autism | Allergies |

Informed consent:

The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures, whatever he/she is suffering from - a latent pathological defect, illnesses or deformities - which would otherwise not come to the attention of the chiropractic physician.

Imagine this picture is your body.
Can you color the area that is hurting you right now?

Authorization to Treat a Minor

I, _____ the undersigning parent/guardian having legal custody/guardianship of _____, a minor, do hereby authorize Heartland Family Chiropractic and its Doctors to perform in judgment, any examination and chiropractic treatment, which is deemed necessary.

I clearly understand and agree that I am personally responsible for payment of all fees charged by this office. Any and all x-rays remain property of the clinic as part of patient's permanent record.

ACKNOWLEDGMENT

I have reviewed the notice of privacy practices (HIPPA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

COMMUNICATION

May we leave messages on any answering device, i.e. home answering machines or voicemails? Yes N

MISSED APPOINTMENTS

There is a possible \$20 fee charged for all appointments that are not cancelled prior to scheduled visit.

Any specific written authorization you provide may be revoked at any time by writing to us at the above address.

Patient: _____

Print Name

Signature: Parent/Legal Guardian

Date

Symptom Survey

List problems from most severe to least severe. Please be as specific as possible.

Problem #1. _____

Location of pain: _____

Severity of pain: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain imaginable) Pain is? Mild Moderate Severe

Progression (circle): same better worse How often is the pain present? Constant 50-75% 25-50% less than 25%

When did you notice the problem? _____ What happened? _____

Better with (circle): rest ice heat stretching exercise pain relievers topical creams other _____

Worse with (circle): sitting standing walking bending twisting lifting movement other _____

Quality of pain (circle): sharp shooting dull ache burning stiff stabbing throbbing numb sore

Does your pain radiate (example: travel into arms, legs etc.) Yes No Where? _____

What time of day is your problem the worse (circle): morning afternoon evening during sleep

What treatment have you received for this condition: medication physical therapy surgery chiropractic other _____ Did it help? Y N

Problem #2. _____

Location of pain: _____

Severity of pain: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain imaginable) Pain is? Mild Moderate Severe

Progression (circle): same better worse How often is the pain present? Constant 50-75% 25-50% less than 25%

When did you notice the problem? _____ What happened? _____

Better with (circle): rest ice heat stretching exercise pain relievers topical creams other _____

Worse with (circle): sitting standing walking bending twisting lifting movement other _____

Quality of pain (circle): sharp shooting dull ache burning stiff stabbing throbbing numb sore

Does your pain radiate (example: travel into arms, legs etc.) Yes No Where? _____

What time of day is your problem the worse (circle): morning afternoon evening during sleep

What treatment have you received for this condition: medication physical therapy surgery chiropractic other _____ Did it help? Y N

Problem #3. _____

Location of pain: _____

Severity of pain: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain imaginable) Pain is? Mild Moderate Severe

Progression (circle): same better worse How often is the pain present? Constant 50-75% 25-50% less than 25%

When did you notice the problem? _____ What happened? _____

Better with (circle): rest ice heat stretching exercise pain relievers topical creams other _____

Worse with (circle): sitting standing walking bending twisting lifting movement other _____

Quality of pain (circle): sharp shooting dull ache burning stiff stabbing throbbing numb sore

Does your pain radiate (example: travel into arms, legs etc.) Yes No Where? _____

What time of day is your problem the worse (circle): morning afternoon evening during sleep

What treatment have you received for this condition: medication physical therapy surgery chiropractic other _____ Did it help? Y N

#4. Additional Complaints (use back of sheet if needed)
