Pediatric Patient Intake Form

for Chiropractic Care at Infinite Healing

Please take a moment to answer the following questions that are designed to maximize your child's health. Many types of stress (physical, mental, chemical) can interfere with your child's growing spine and nervous system. Spinal health is crucial to allow optimal nervous system development. So please remember to ask questions, it is for your benefit.

Child's Name:_____

Parent/Guardian Name(s): _____

Address: _____ City:_____

Postal Code: _____

Home Phone#:_____Alternate Number(s): _____

Email Address (Used for Appointment Reminders):_____

Child's Date of Birth: M_____ D_____ YR _____ Age: _____

1. **Has your child ever received chiropractic care?** ☐YES ☐NO If yes, when was their last visit? _____

2. **During the pregnancy did you do, or take, any of the following?**

A. Smoke	☐Yes	☐No	If so, how often? _____
B. Drink	☐Yes	☐No	If so, how often? _____
C. Take drugs	☐Yes	☐No	If so, how often? _____
D. Take medications	☐Yes	☐No	If so, how often? _____

3. **Please check the appropriate answer:**

Birth Place: ☐Home ☐Hospital ☐Birth Center **Type:** ☐Vaginal ☐C-Section
Procedures: ☐Forceps ☐ Vacuum Extraction
Complications: _____
APGAR score:_____ **Birth Weight:** _____ **Birth Length**: _____

4. **How was the baby when he/she was born?** _____

5. **Was/Is your child Breast-fed?** ☐YES ☐NO

6. **Does your child have any food or juice intolerance?** _____

7. **Have you noticed any loss of appetite or any other recent eating disorders?**
_____

8. **Is your baby/child...**

Raising their head?	☐Yes	☐No
Sitting?	☐Yes	☐No
Standing?	☐Yes	☐No
Crawling?	☐Yes	☐No
Walking?	☐Yes	☐No

9. **Which contact sports does your child participate in?**

☐Soccer ☐Football ☐Gymnastics ☐Karate ☐Hockey ☐Basketball ☐Dance

☐ Other_____

9. According to the National Safety Council, approximately 50% of infants fall head first from a high place (bed, changing table, etc.) during their first year of life. Has this happened to your child?
☐YES ☐NO

10. Does your child frequently wake up in the night crying? ☐YES ☐NO Any other changes in your child's sleep patterns?
_____

11. **Please check the following and give the appropriate age of each:**

Chicken Pox: ☐YES ☐NO Age: _____

Mumps: ☐YES ☐NO Age: _____

Rubella (German Measles): ☐YES ☐NO Age: _____

Whooping Cough: ☐YES ☐NO Age: _____

Other (Please specify): _____ Age: _____

Vaccinations: (Please list type and age): _____

12. **Has your child experienced, or are they experiencing, any of the following?**

☐ Ear infections/ear ache	How often?_____	☐ Hyperactivity/ADD	How often?_____
☐ Asthma	How often?_____	☐ Diarrhea	How often? _____
☐ Tonsillitis	How often?_____	☐ Sinus Infections	How often? _____
☐ Upper Respiratory infection	How often?_____	☐ Seizures	How often? _____
☐ Jaundice	How Long?_____	☐ Bedwetting	How often? _____
☐ "Growing pains"	How often?_____	☐ Stomach problems	How often?_____
☐ Constipation	How often?_____	☐ Allergies	To What?_____
☐ Scoliosis	How severe?_____		

13. How many prescriptions of **antibiotics** has your child taken during:

The past 6 months? _____

Total his/her lifetime? _____

14. How many prescription **medications** has your child taken during:

The past 6 months? _____

Total his/her lifetime? _____

15. Is there any significant family history we should know about? _____

_____

16. What was your reason for contacting us? _____

_____

17. Do you have any concerns about bringing your child for Chiropractic care? ☐Yes ☐No
If you answered yes, what are they? _____

_____

18. How did you hear about our clinic? If you were referred by another patient please let us know so we can thank them!
_____

All the above information is true and accurate to the best of my knowledge.

_____ _____ _____

Parent/Guardian Name **Parent/Guardian Signature** **Date**