



### PEDIATRIC HISTORY INTAKE

Date: \_\_\_\_\_

It is a pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To help us serve you better, please complete the following information. We look forward to working with you to build better health for your family.

Child's Name: \_\_\_\_\_ SS#: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Male / Female (circle one)      Weight: \_\_\_\_\_ lbs.      Height: \_\_\_\_\_ ft. \_\_\_\_\_ in.

Parents /Guardian: \_\_\_\_\_ Referred By: \_\_\_\_\_

Contact email: \_\_\_\_\_

**Purpose for contacting our office?** \_\_\_\_\_

\_\_\_\_\_

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Have you seen other doctors for this condition?    yes    no

If yes, doctor's names and prior treatments: \_\_\_\_\_

\_\_\_\_\_

List other health problems: \_\_\_\_\_

Check any of the following conditions your child has suffered from during the past six months:

- |  |                                       |                                   |   |                                    |
|--|---------------------------------------|-----------------------------------|---|------------------------------------|
| <input type="checkbox"/> ear infections    | <input type="checkbox"/> scoliosis    | <input type="checkbox"/> seizures | <input type="checkbox"/> chronic colds      | <input type="checkbox"/> headaches |
| <input type="checkbox"/> recurring fevers  | <input type="checkbox"/> allergies    | <input type="checkbox"/> asthma   | <input type="checkbox"/> car accident       | <input type="checkbox"/> colic     |
| <input type="checkbox"/> growing/back pain | <input type="checkbox"/> bed wetting  | <input type="checkbox"/> ADHD     | <input type="checkbox"/> digestive problems |                                    |
| <input type="checkbox"/> temper tantrums   | <input type="checkbox"/> other: _____ |                                   |   |                                    |

Family history: \_\_\_\_\_

\_\_\_\_\_

Previous Chiropractor: \_\_\_\_\_ Date of last visit: \_\_\_\_\_

Reason: \_\_\_\_\_

Name of pediatrician: \_\_\_\_\_ Date of last visit: \_\_\_\_\_

Reason: \_\_\_\_\_

Are you satisfied with the care your child has received at the pediatrician?  yes  no

Number of doses of antibiotics your child has taken:

During the past 6 mos. \_\_\_\_\_ // Total for their lifetime. \_\_\_\_\_

Number of doses of prescription medications your child has taken:

During the past 6 mos. \_\_\_\_\_ // Total for their lifetime. \_\_\_\_\_

Please list:

Medication	Dosage	For What Condition?	How long were they taking this?

Vaccination History:  standard  selective  none  other: \_\_\_\_\_

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### **Prenatal History**

Name of Obstetrician / Midwife: \_\_\_\_\_

Complications during pregnancy:  yes  no // If yes, explain: \_\_\_\_\_

\_\_\_\_\_

Medications during pregnancy:  yes  no // If yes, explain: \_\_\_\_\_

\_\_\_\_\_

Ultrasounds during pregnancy:  yes  no // How many?: \_\_\_\_\_

Cigarette / Alcohol use during pregnancy?  yes  no

Location of birth:  birthing center / midwifery  hospital  home  other: \_\_\_\_\_

Which of the following did you have?  Natural / Vaginal Delivery  Birth intervention

If birth intervention, please check all that apply:

- Anesthesia
- Forceps
- Intensive Care
- Other: \_\_\_\_\_
- Breech Presentation
- Vacuum Extraction
- Cesarean Section: emergency or planned (circle one)

Face Presentation

Induced Labor

Medications during delivery:  yes  no // If yes, explain: \_\_\_\_\_

\_\_\_\_\_

Complications during pregnancy:  yes  no // If yes, explain: \_\_\_\_\_

Genetic disorders or disabilities:  yes  no // If yes, please list: \_\_\_\_\_

Birth Weight: \_\_\_\_\_ Birth Length: \_\_\_\_\_ APGAR Scores: \_\_\_\_\_

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### **Feeding History**

Breast Fed:  yes  no How long? \_\_\_\_\_

Does the Baby prefer one side or the other?  yes  no

Formula Fed:  yes  no How long? \_\_\_\_\_ Type: \_\_\_\_\_

Introduced to: Solid foods at: \_\_\_\_\_ months Cow's milk at: \_\_\_\_\_ months

Food / Juice allergies or intolerances:  yes  no // If yes, please list: \_\_\_\_\_

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### **Developmental History**

Your child's spine is most vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention of vertebral subluxation (spinal nerve interference).

At what age was your child able to:

\_\_\_\_\_ Respond to sound

\_\_\_\_\_ Cross crawl

\_\_\_\_\_ Respond to visual stimuli

\_\_\_\_\_ Stand alone

\_\_\_\_\_ Hold head up

\_\_\_\_\_ Walk alone

\_\_\_\_\_ Sit up

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e. a bed, changing table, stairs, chair, etc).

Has your child have a fall similar to what was described above?  yes  no // If yes, explain: \_\_\_\_\_

Is / Has your child been involved in any high impact or contact sports? (i.e. soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.)  yes  no

If yes, please list: \_\_\_\_\_

Has your child ever been involved in a car accident?  yes  no // If yes, explain: \_\_\_\_\_

Has your child been seen by a physician on an emergency basis?  yes  no // If yes, explain: \_\_\_\_\_

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Other Traumas not described above?  yes  no // If yes, explain: \_\_\_\_\_

Prior surgery:  yes  no // If yes, please list: \_\_\_\_\_

Menarche (first menstrual cycle):  yes  no Age: \_\_\_\_\_

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**Childhood Diseases**

- |                                      |            |   |            |
|--------------------------------------|------------|---|------------|
| <input type="checkbox"/> Chicken Pox | Age: _____ | <input type="checkbox"/> Mumps          | Age: _____ |
| <input type="checkbox"/> Rubella     | Age: _____ | <input type="checkbox"/> Whooping Cough | Age: _____ |
| <input type="checkbox"/> Rubeola     | Age: _____ | <input type="checkbox"/> Other: _____   | Age: _____ |

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**Lifestyle**

- |  |   |
|--|---|
| <input type="checkbox"/> Eat healthy           | <input type="checkbox"/> Exercise         |
| <input type="checkbox"/> Enjoys sports         | <input type="checkbox"/> Enjoys hobbies   |
| <input type="checkbox"/> Takes vitamins        | <input type="checkbox"/> Takes probiotics |
| <input type="checkbox"/> Drink plenty of water | <input type="checkbox"/> Other: _____     |

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We are here to serve you, and encourage you to ask questions. Your participation is vital and will help determine your results.

**Authorization for care of minor**

I hereby authorize this office and its Doctors to administer care to my child as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Parent/guardian name (please print): \_\_\_\_\_

Parent/guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to the patient: \_\_\_\_\_



## Who is financially responsible for your bill?

- Myself - Self Pay
  - Please give your photo ID to the front desk.
- Medicare
  - Please give your photo ID to the front desk.
  - Please ask front desk for an ABN.
- Medicaid
  - Please give your card/stickers and photo ID to the front desk.
- Worker's Compensation
  - Please give your photo ID to the front desk.
  - Please ask front desk for additional WC paperwork.
- Personal Injury (Auto)
  - Please give your photo ID to the front desk.
  - Please ask front desk for additional PI paperwork.
- Personal Health Insurance
  - Please give your insurance card and photo ID to the front desk.

Company Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Insured Person's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name of Primary Policy holder: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Relationship to you: \_\_\_\_\_ SS # of Primary: \_\_\_\_\_

### **By signing below:**

- I understand and agree that health and accident insurance policies are an arrangement between my insurance carrier and myself.
- I understand that the Doctor's office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's office will be credited to my account upon receipt.
- I understand that if I suspend or terminate my insurance, any fees for services rendered me will be immediately due and payable.
- **I understand that payment from insurance companies are an estimate only.**
- **I agree that I am financially responsible for all services incurred in this office regardless of my insurance coverage.**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ CA Verification: \_\_\_\_\_

Guardian, if minor: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_