



## Pediatric Chiropractic Intake Form

### Patient (Child) Information:

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Sex: Male Female Date of Birth: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
 Patient SSN: \_\_\_\_\_ Name of Parents/Guardian: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Email: \_\_\_\_\_ Would you like our newsletter emailed to you: Y N  
 Whom may we thank for referring you? \_\_\_\_\_  
 Authorized Representative/Parent/Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_

### 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  
 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

### Feeding History:

Breast Fed: Y N How long: \_\_\_\_\_  
 Formula Fed: Y N How long: \_\_\_\_\_  
 Introduced to: Solids at \_\_\_\_\_ Months  
 Cow's milk at \_\_\_\_\_ Months  
 Food Allergies or Intolerances: Y N  
 List: \_\_\_\_\_

### Childhood Diseases:

Chicken Pox: Y N Age: \_\_\_\_\_  
 Rubella: Y N Age: \_\_\_\_\_  
 Rubeola: Y N Age: \_\_\_\_\_  
 Mumps: Y N Age: \_\_\_\_\_  
 Whooping Cough: Y N 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 \_\_\_\_\_ Stand Alone  
 \_\_\_\_\_ Hold Head Up Alone \_\_\_\_\_ Walk Alone \_\_\_\_\_  
 Sit Up 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: \_\_\_\_\_

**Review of Systems**

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

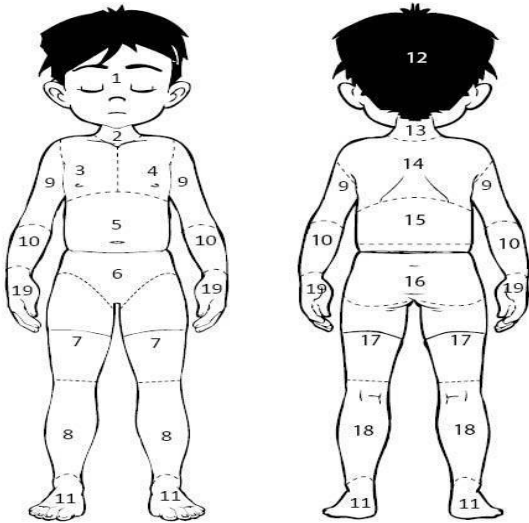
- |   |  |   |  |   |
|---|--|---|--|---|
| <input type="checkbox"/> Headaches          | <input type="checkbox"/> Postural Imbalances   | <input type="checkbox"/> Growing Pains  | <input type="checkbox"/> Scoliosis     | <input type="checkbox"/> Tonsillitis    |
| <input type="checkbox"/> Asthma             | <input type="checkbox"/> Torticollis           | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Seizures      | <input type="checkbox"/> Sleep Problems |
| <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Bedwetting            | <input type="checkbox"/> PDD/Autism     | <input type="checkbox"/> ADD/ADHD      | <input type="checkbox"/> Frequent Fever |
| <input type="checkbox"/> Colic              | <input type="checkbox"/> Learning Difficulties | <input type="checkbox"/> Acid Reflux    | <input type="checkbox"/> Hip Dysplasia | <input type="checkbox"/> Allergies      |

How would you rate your child's diet?  Well Balanced  Average  High sugar/processed foods Does your child consume artificial sweeteners? Y N

Number of hours your child sleeps: \_\_\_\_\_ hours per night \_\_\_\_\_ hours per day/naps

Sleep Quality:  Good  Fair  Poor

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



HALLAGRENO 2010

- |                 |                 |                   |                  |
|-----------------|-----------------|-------------------|------------------|
| 1 - FACE        | 7 - THIGHS      | 12 - BACK OF HEAD | 17 - BACK THIGHS |
| 2 - NECK        | 8 - LEGS        | 13 - BACK OF NECK | 18 - BACK LEGS   |
| 3 - LEFT CHEST  | 9 - UPPER ARMS  | 14 - UPPER BACK   | 19 - HANDS       |
| 4 - RIGHT CHEST | 10 - LOWER ARMS | 15 - MIDDLE BACK  |                  |
| 5 - STOMACH     | 11 - FEET       | 16 - LOWER BACK   |                  |
| 6 - ABDOMEN     |                 |                   |                  |

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**Authorization to Treat a Minor**

I, \_\_\_\_\_ the undersigning parent/guardian having legal custody/guardianship of \_\_\_\_\_, a minor, do hereby authorize, request and direct Dr. Ley and whomever she might designate as assistant to perform in judgment any examination and chiropractic diagnosis or treatment which is deemed necessary.

Any specific written authorization you provide may be revoked at any time by writing to us at the address provided on the front of this form.

Patient: \_\_\_\_\_

Print Name

Signature: \_\_\_\_\_

Parent/Legal Guardian