Family Chiropractic CLINIC

DR. JEFF HAND
DR. JENNIFER PERSON
DR. JOSH HOLBROOK

Doctors of Chiropractic

Pediatric Intake Form

Child's Full Name: ____ Date:___________________

Parent #1 Name: ___________________________ Parent #2 Name: ___________________________

Child's Home Address: ____

City: ________________________________ State: ________________ Zip:_________________________

Home Telephone: ____________________ Parent #1 Work and/or Cell:___________________________

Parent #2 Work and/or Cell:____

Parent Email Address(es):____

Whom may we thank for referring you? ____

Has he/she ever had chiropractic care before? ☐ Yes ☐ No For what problem? __________________

Birth Date:________________ Sex: M F Birth Weight:___________ Current age of child:_______

Type of Birth: ☐ Vaginal ☐ Forceps ☐ Breech ☐ Cesarean ☐ Home ☐ Birth Center ☐ Hospital

Were there any problems during pregnancy and/or labor? _____________________________________

____

____

Were there any problems with the baby immediately after birth? ______________________________

Congenital Anomalies or Defects: ____

Infant Feeding: ☐ Breast ☐ Bottle ☐ Formula ☐ Other Food or Drink Information ________________

Number of hours child sleeps daily:_________________ Quality of Sleep ☐ Good ☐ Fair ☐ Poor

Explain:____

Obstetrician and/or Midwife Name:_________________________ Location:______________________

Pediatrician and/or Family MD Name:_______________________ Location:______________________

Date of the Last Visit to the Doctor:______________ Purpose of that Visit: _______________________

Child's Name________________________________

Purpose of the appointment today with the Chiropractor: (Please note it must be a spinal complaint if you are wanting insurance coverage for this visit): ____
____

Developmental History

At what age did the child first:
Hold Head Up:_____________________________
Sit:______________________________________
Crawl:____________________________________
Stand:____________________________________
Walk:_____________________________________

Childhood Diseases

At what age did the child have:
Chicken Pox:_________________________________
Rubella:_____________________________________
Whooping Cough:__________________________
Mumps:_____________________________________
Other:______________________________________

Has this child ever suffered from (please check any that apply):

□ Allergies	□ Broken Bones	□ Fainting	□ Neck Problems
□ Anemia	□ Constipation	□ "Growing Pains"	□ Poor Appetite
□ Arm problems	□ Colds/Flu	□ Headaches	□ Paralysis Problems
□ Arthritis	□ Convulsions	□ Heart Trouble	□ Rheumatic Fever
□ Asthma	□ Diabetes	□ Hyperactivity	□ Hernias
□ Backaches	□ Diarrhea	□ Hypertension	□ Sinus Trouble
□ Bed Wetting	□ Digestive Disorders	□ Joint Problems	□ Sleeping Problems
□ Behavioral Problems	□ Dizziness	□ Leg Problems	□ Stomach Aches
□ Blood Disorders	□ Chronic Earaches	□ Muscle Jerking	□ Walking Problem

□ Other Problems (please list):____
____

Surgery Health History or Additional Information:

Surgery Information:____

Medications:____

Accidents:____

Family Health History:____

Accident Information:

Is this condition due to an accident? Yes No Date of Injury:_________________________
Type: □ Auto □ Work □ Home □ Other

____
Guardian Signature Date