NEW GEN CHIROPRACTIC

PEDIATRIC INTAKE & HISTORY

PATIENT INFORMATION

Patient Name _____

Address _____

City _____ **State** _____ **Zip Code** _____

Home Phone _____

Cell Phone _____

Email _____

Sex ☐ M ☐ F Age _____ **Birthday** _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Contact Number _____

Mother's Name _____

Mother's Occupation _____

Mother's Phone _____

Mother's Email _____

Father's Name _____

Father's Occupation _____

Father's Phone _____

Father's Email _____

Who may we thank for referring you?

_____

HOW CAN WE HELP YOUR CHILD?

☐ Wellness Checkup ☐ Other: _____

_____

If your child is already experiencing a symptom, please describe it:

_____

_____

_____

_____

Has your child been treated on an emergency basis? ☐ Yes ☐ No

Please describe: _____

_____

PRIOR MEDICAL HISTORY

_____

_____

_____

PREGNANCY HISTORY

Did you experience any complications during your pregnancy? (check all that apply)

☐ Back/Other Pain ☐ Gestational Diabetes ☐ Pre/Eclampsia ☐ Strep B ☐ Nauseau/Vomitting

☐ Pre-Term ☐ Fatigue ☐ Swelling ☐ Other (please describe) _____

BIRTH HISTORY

Type of birth (check all that apply):

☐ Hospital ☐ Birth Center ☐ Home ☐ Normal / Vaginal ☐ Breech

☐ Cesarean ☐ Scheduled/Induced ☐ Epidural

Problems during labor / delivery? _____

☐ Antibiotics ☐ Congenital Anomalies ☐ Failure to Thrive ☐ Jaundice ☐ Meconium

☐ Respiratory Distress ☐ Extended Hospitalization ☐ Other _____

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GROWTH & DEVELOPMENT

Infant Feeding ☐ Breast ☐ Bottle ☐ Formula

Number of hours of sleep each night: _____ **Quality of Sleep:** _____

At what age did the child:

Respond to sound: _____ **Crawl:** _____ **Hold Head Up:** _____

Stand: _____ **Sit Unsupported:** _____ **Walk Unsupported:** _____

CHILDHOOD DISEASES, ILLNESSES & VACCINATIONS

Has your child had (check all that apply)?:

☐ Chicken Pox ☐ Measles ☐ Rubeola

☐ Mumps ☐ Rubella ☐ Pertussis/Whooping Cough

Has your child ever suffered from (check all that apply)?:

☐ Allergies ☐ Broken Bones ☐ Digestive Issues (constpiation/diarrhea) ☐ Hypertension ☐ Orthopedic Problems

☐ Anemia ☐ Chronic Ear Aches ☐ Dizziness ☐ Jeuvenile Rheumatroid Arthritis ☐ Paralysis

☐ Arm Problems ☐ Colds/Flu ☐ Fainting ☐ Joint Problems ☐ Poor Apetite

☐ Asthma ☐ Colic ☐ Headaches ☐ Leg Problems ☐ Ruptures/Hernias

☐ Back Ahes ☐ Convulsions/Seizures ☐ Heart Trouble ☐ Neck Problems ☐ Sinus Trouble

☐ Bed Wedding ☐ Delayed Speech ☐ Hyperactivity ☐ Neuritis ☐ Tuberculosis

☐ Behavorial Problems ☐ Diabetes ☐ Walking Problems

Have you vaccinated your child?

☐ No ☐ Yes ☐ As Scheduled ☐ Delayed Schedule

ALLERGIES, MEDICATIONS, SURGERIES & FAMILY HISTORY

Allergies (List)

_____

_____

Medications (List)

_____

_____

Surguries (List)

_____

_____

Family History (List)

_____

_____

SIBLINGS

How many children do you have? _____ **Number of pregnancies:** _____

Children's Age(s): _____ **Are you currently pregnant?** ☐ No ☐ Yes ☐ Yes, I'm due: _____

Children's health concerns: _____ **Health concerns regarding this pregnancy?** _____

_____ _____

Have you vaccinated your child?

I hereby authorize this clinic and its doctor(s) to administer care as they so deem necessary to my son/daughter/ward.

Signed: _____ **Witnessed:** _____ **Date:** _____