Pediatric Intake

Name *

Date of Birth *

Gender

- [ ] Male
- [ ] Female

Phone Number *

Email *

Home Address *

Parent/Guardian Name(s) *

Please select any treatments your child has had in the past

- [ ] Chiropractic
- [ ] Acupuncture/Acupressure
- [ ] Massage Therapy
- [ ] Cupping
- [ ] Reiki
- [ ] Physical Therapy
- [ ] Other:

Who is your child's primary care physician?

Please list any medications that your child is taking

Please list your child's hospitalization and surgical history (including this year)

Please list any major incidents, accidents, falls, and/or fractures your child has sustained in his/her lifetime (including this year)

How did you hear about us?

Current Health Conditions

What are your child's complaints? *

When did the condition start?

How did the problem start?

- [ ] Suddenly
- [ ] Gradually
- [ ] Post-Injury

Has your child received care for this current condition?

- ( ) Yes ( ) No

If yes, please specify

What makes the problem better?

What makes the problem worse?

Pregnancy History

Any fertility issues?

- ( ) Yes ( ) No

If yes, please specify

Child's birth was

- [ ] Natural vaginal birth
- [ ] Scheduled C-section
- [ ] Emergency C-section

Please indicate any applicable interventions or complications

- [ ] Breach
- [ ] Induction
- [ ] Pain meds
- [ ] Epidural
- [ ] Episiotomy
- [ ] Vacuum extraction
- [ ] Forceps
- [ ] Other:

How many weeks was your child born?

Child's birth weight

Child's birth height

Please describe any other concerns or notable remarks about your child's labor and/or delivery

Growth & Developmental History

Is/was your child breastfed?

- ( ) Yes ( ) No

If yes, how long?

Difficulty breastfeeding?

- ( ) Yes ( ) No

Did they ever use formula?

Yes No

If yes, at what age?

If yes, what type?

Did/does your child suffer from colic, reflux, or constipation as an infant? If yes, please explain

Did/does your child frequently arch their neck/back, feel stiff, or bang their head? If yes, please explain

Please explain any food intolerance or allergies, and when they began

Difficulty sleeping?

Yes No

If yes, please explain

Behavioral, social, or emotional issues?

Yes No

If yes, please explain

Health Goals For Your Child

What are your top three health goals for your child?

Is there anything else you would like to tell us?

Any questions or concerns you want to be sure to ask today?

Parent/Guardian Signature *

Date