Smith Family Chiropractic

PEDIATRIC INTAKE FORM

PATIENT INFORMATION **CONFIDENTIAL**

Thank you for the opportunity to serve you. If you have any questions, do not hesitate to ask. We will be happy to help.

Name_____ Date_____/_____/_____ S/S_____-_____-_____

First MI Last

Birth Date_____/_____/_____ **Current**: Height_____Weight_____ **Sex:** ❒ Female ❒ Male

Parent/Guardian Name_____ Phone_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Work Phone_____ Cell Phone_____

Who may we thank for referring you to us?_____

HEALTH HISTORY

Does your child currently have or have they previously had any of the following symptoms**:**

❒ Nervousness	❒ Sleeping Problems	❒ Light Sensitivity to Eyes	❒ Headaches
❒ Ear infections	❒ Fatigue	❒ Ringing/ Buzzing in Ears	❒ Neck Pain
❒ Colic	❒ Chest Pain	❒ Upset Stomach	❒ Neck Stiffness
❒ Excessive Spitting up	❒ Shortness of Breath	❒ Constipation	❒ Mid Back Pain
❒ Tension	❒ Cold Sweats	❒ Diarrhea	❒ Low Back Pain
❒ Asthma	❒ Fever	❒ Urinary Problems	❒ Arm Pain
❒ Bedwetting	❒ Fainting	❒ Acid Reflux	❒ Leg Pain
❒ ADD/ADHD	❒ Dizziness	❒ Ulcers	❒ Cold Hands
❒ Irritability	❒ Loss of Balance	❒ Allergies	❒ Cold Feet

Chief Health Concerns: _____

_____

List other types of Care undergone for this complaint (including medications): _____

_____

Date of onset: _____ Onset was: ❒ Sudden ❒Gradual ❒ Associated with an event

Duration of problem (episode): _____How often do you notice the symptoms? ❒ Constantly ❒ Frequently ❒ Occasionally

Does anything alleviate the symptoms?_____ Is the condition getting worse? ❒ No ❒ Yes

Effects of problems on body function and daily activities:_____

_____

Was there an injury or fall? □ No □ Yes, Describe_____

Have you had x-rays before? ❒ No ❒ Yes, When? _____ What areas? _____

List any other concerns: _____

History of Birth:

❒ Hospital ❒ Birthing Center ❒ Home ❒ Midwife Birth Weight: _____ Duration of Gestation: _____ weeks

Was the birth assisted? ❒ No ❒ Yes, if Yes: ❒ forceps ❒ vacuum ❒ c-section ❒ induced labor

Evidence of Birth Trauma? (i.e., bruises, odd shaped head, stuck in birth canal, fast or excessively long labor, respiratory depression, cord around neck) _____

Medication delivered to mother at birth? ❒ No ❒ Yes, what? _____

Duration of labor: _____ Complications at birth: ❒ No ❒Yes, explain: _____

Growth and Development:

Was the infant alert and responsive within twelve hours of delivery? ❒ No ❒Yes If No, Explain: _____

At what age did the child: Hold head up:_____ Sit alone: _____ Crawl:_____ Walk:_____

Do your child's sleeping patterns seem normal to you: ❒ Yes ❒ No, _____

Chemical Stressors:

Was (is) the baby breast-fed? ❒ Yes, for how long? _____ ❒ No, explain reason _____

Formula introduced at age: _____ Type of formula used: _____

Cow's milk introduced at age: _____ Began solid food at age: _____ Type: _____

Food/Juice intolerance: ❒ No ❒ Yes, type: _____

During pregnancy did the mother: Smoke? ❒ No ❒ Yes Drink Alcohol? ❒ No ❒Yes

Supplements taken during pregnancy: _____ ❒ None

Drugs taken during pregnancy: _____ ❒ None

Any other complications during pregnancy: _____ ❒ None

Has your child received vaccinations: ❒ No❒ Yes, which ones and reactions _____

Has your child received antibiotics: ❒ No ❒ Yes, Total courses of antibiotics to date _____

Current medications and reasons: _____❒ None

Surgical History: _____ ❒ None

DATE: _____/_____/_____ **PARENT/ GUARDIAN Signature**:_____