PEDIATRIC INTAKE & HISTORY

PATIENT INFORMATION

Patient Name _____
Address _____
City _____ State _____
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: _____

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 _____

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
❑ Anemia
❑ Arm Problems
❑ Asthma
❑ Back Aches
❑ Bed Wetting
❑ Behavioral Problems
❑ Broken Bones
❑ Chronic Ear Aches
❑ Colds/Flu
❑ Colic
❑ Convulsions/Seizures
❑ Delayed Speech
❑ Diabetes
❑ Digestive Issues (constipation/diarrhea)
❑ Dizziness
❑ Fainting
❑ Headaches
❑ Heart Trouble
❑ Hyperactivity
❑ Hypertension
❑ Jeuvenile Rheumatroid Arthritis
❑ Joint Problems
❑ Leg Problems
❑ Neck Problems
❑ Neuritis
❑ Orthopedic Problems
❑ Paralysis
❑ Poor Appetite
❑ Ruptures/Hernias
❑ Sinus Trouble
❑ Tuberculosis
❑ Walking Problems

Have you vaccinated your child?

❑ No ❑ Yes ❑ As scheduled ❑ Delayed Schedule

ALLERGIES, MEDICATIONS, SURGERIES & FAMILY HISTORY

ALLERGIES (list)

_____

_____

MEDICATIONS (list)

_____

_____

SURGERIES (list)

_____

_____

FAMILY HISTORY (list)

_____

_____

SIBLINGS

How many children do you have? _____

Children's' Ages: _____

Childrens' health concerns: _____

_____

Number of pregnancies: _____

Are you currently pregnant? ❑ No ❑ Yes, I'm due: _____

Health concerns regarding this pregnancy? _____

_____

Authorization for Care of Minor

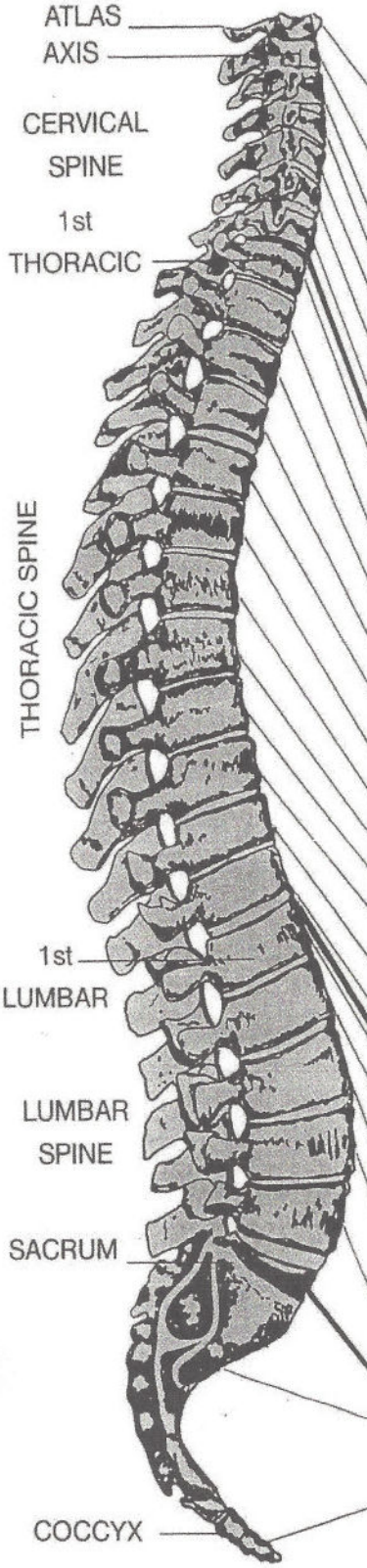
I hereby authorize this clinic and its doctor(s) to administer care as they so deem necessary to my son/daughter/ward.

Signed: _____ Witnessed: _____ Date: _____

SYMPTOMS OF SPINAL MISALIGNMENT QUESTIONNAIRE

"The nervous system controls and coordinates all organs and structures of the human body." (*Gray's Anatomy*, 29th Ed., page 4). Misalignments of spinal vertebrae and discs may cause irritation to the nerves which could affect the areas listed. Please help us help you by placing a check mark in the appropriate box under the "Possible Effects" column to indicate your symptoms.

Please Check Below



Vertebrae	Areas Controlled by Nerves*		Possible Effects of a Malfunction
1C	Blood supply to the head, pituitary gland, scalp, bones of the face, brain, inner and middle ear, sympathetic nervous system.	NECK REGION	☐ headaches, ☐ nervousness, ☐ insomnia, ☐ head colds, ☐ high blood pressure, ☐ migraine headaches, ☐ nervous breakdowns, ☐ amnesia, ☐ chronic tiredness, ☐ dizziness.
2C	Eyes, optic nerves, auditory nerves, sinuses, mastoid bones, tongue, forehead.		☐ sinus trouble, ☐ allergies, ☐ pain around the eyes, ☐ earache, ☐ fainting spells, ☐ certain cases of blindness, ☐ crossed eyes, ☐ deafness.
3C	Cheeks, outer ear, face bones, teeth, trifacial nerve.		☐ neuralgia, ☐ neuritis, ☐ acne or pimples, ☐ eczema.
4C	Nose, lips, mouth, eustachian tube.		☐ hay fever, ☐ runny nose, ☐ hearing loss, ☐ adenoids.
5C	Vocal cords, neck glands, pharynx.		☐ laryngitis, ☐ hoarseness, ☐ throat conditions such as sore throat or quinsy.
6C	Neck muscles, shoulders, tonsils.		☐ stiff neck, ☐ pain in upper arm, ☐ tonsillitis, ☐ chronic cough, ☐ croup.
7C	Thyroid gland, bursae in the shoulders, elbows.		☐ bursitis, ☐ colds, ☐ thyroid conditions.
1T	Arms from the elbows down, including hands, wrists, and fingers; esophagus and trachea.	MID-BACK	☐ asthma, ☐ cough, ☐ difficult breathing or shortness of breath, ☐ pain in lower arms and hands.
2T	Heart, including its valves and covering; coronary arteries.		☐ functional heart conditions and certain chest conditions.
3T	Lungs, bronchial tubes, pleura, chest, breast.		☐ bronchitis, ☐ pleurisy, ☐ pneumonia, ☐ congestion, ☐ influenza.
4T	Gall bladder, common duct.		☐ gall bladder conditions, ☐ jaundice, ☐ shingles.
5T	Liver, solar plexus, circulation (general).		☐ liver conditions, ☐ fevers, ☐ blood pressure problems, ☐ poor circulation, ☐ arthritis.
6T	Stomach.		☐ stomach troubles or nervous stomach, ☐ indigestion, ☐ heartburn, ☐ dyspepsia.
7T	Pancreas, duodenum.		☐ ulcers, ☐ gastritis.
8T	Spleen.		☐ lowered resistance.
9T	Adrenal and supra-renal glands.		☐ allergies, ☐ hives.
10T	Kidneys.		☐ kidney troubles, ☐ hardening of the arteries, ☐ chronic tiredness, ☐ nephritis, ☐ pyelitis.
11T	Kidneys, ureters.		☐ skin conditions such as acne, ☐ pimples, ☐ eczema, ☐ or boils.
12T	Small intestines, lymph circulation.		☐ rheumatism, ☐ gas pains, ☐ certain types of sterility.
1L	Large intestines, inguinal rings.	LOW BACK	☐ constipation, ☐ colitis, ☐ dysentery, ☐ diarrhea, ☐ some ruptures or hernias.
2L	Appendix, abdomen, upper leg.		☐ cramps, ☐ difficult breathing, ☐ minor varicose veins.
3L	Sex organs, uterus, bladder, knees.		☐ bladder troubles, ☐ menstrual troubles such as painful or irregular periods, ☐ miscarriages, ☐ bed wetting, ☐ impotency, ☐ change of life symptoms, ☐ many knee pains.
4L	Prostate gland, muscles of the lower back, sciatic nerve.		☐ sciatica, ☐ lumbago, ☐ difficult, painful, or too frequent urination, ☐ backaches.
5L	Lower legs, ankles, feet.		☐ poor circulation in the legs, ☐ swollen ankles, weak ankles and arches, ☐ cold feet, ☐ weakness in the legs, ☐ leg cramps.
SACRUM	Hip bones, buttocks.	PELVIS	☐ sacro-iliac conditions, ☐ spinal curvatures.
COCCYX	Rectum, anus.		☐ hemorrhoids (piles), ☐ pruritis (itching), ☐ pain at end of spine on sitting.

*Directly or indirectly controlled

For further explanation of the conditions shown above, and information about those not shown, ask your Doctor of Chiropractic.

Our Privacy Policy

In our office, all health information is considered confidential and we are careful about how we use it. This notice describes how your health information may be used and disclosed, and how you can get access to this information. Please read about your health information and let us know if you have any questions.

We may share your information to:

* Treat you, Collect payment, Run our office, Do research, Inform you about other services, Discuss your case with family, Include you in care classes, Thank you for referring other patients.

We may use your health information for:

Health and safety reasons, Reporting to law officials, Reporting victims of abuse, Court hearings and filings, Reporting to worker's compensation.

You have the right to:

Request a copy of your health record, Request a list of whom we share your information, Ask us to limit the information we share, Advise our management if you believe your privacy rights have been violated, Request confidential communications, Amend your protected health information.

Authorization of Care

I authorize and agree to allow the doctor and/or his designated staff to work with my spine or the spine of the charge I represent through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration of normal bio-mechanical and neurological function. I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges. The Doctor and/or his staff will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another healthcare practitioner, or are not related to the spinal structural conditions diagnosed at this clinic. I also clearly understand that if I do not follow the doctors and/or staff's specific recommendations at this clinic that I will not receive the full benefit from these programs;

I, _____ have read and fully understand the above statements and consent to an examination and accept chiropractic care.

(print name)

_____ _____

(signature) (date)

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CHIROPRACTIC