Dr. Nathan Siebenaller
335 N. Main St, Suite 2, Springboro, OH 45066 | P (937) 748-9708 | F (937) 806-3281
www.fullyalivechiropractic.com

PEDIATRIC INTAKE FORM FOR CHILDREN AGES 4-8

HELLO AND WELCOME TO FULLY ALIVE!

Who may we thank for referring you/how did you hear about our office? _____
Why are you seeking chiropractic care for your child? □Wellness □Specific Condition
*If condition, please *briefly* describe:

Has your child received chiropractic care in the past? □Yes □No
*If YES, what was the reason for the care? _____
*From whom did your child receive care? _____
*Approximate date of last visit: _____

About the Child

Name: _____
□Male □Female
Date of Birth: _____
Age: _____
Weight: _____
Address: _____
City: _____ Zip: _____
MD/Pediatrician: _____
*May we communicate with this physician about your child's health information? □Yes □No

About the Parents

Mother: _____
Phone: _____
Father: _____
Phone: _____
Marital Status: □Single □Married □Divorced
E-mail: _____
Emergency Contact #: _____
Emergency Contact Name:
_____

Pre-Natal/Child Health History

During pregnancy did you use: □Caffeine □Medications □Alcohol/Tobacco/Drugs □Supplements
*If yes, please explain: _____
Did you experience any illnesses OR traumatic events while pregnant? □Yes □No
*If yes, please explain: _____
Was the Delivery: □Non-medicated □Chemically Induced □C-Section □Forceps/Vacuum □Premature
*Please explain: _____
Child's birth weight: _____ *If premature, at how many weeks were they born? _____
Describe any genetic conditions your child has been diagnosed with: _____
Any serious physical traumas (falls, car accidents, etc)? _____
Has your child ever been hospitalized/had surgery? □Yes □No
*If yes, explain: _____
Describe any broken bones your child has had: _____

Child Health History

Did you choose to vaccinate your child? □Yes □No *If Yes, □Delayed Schedule □Pediatrician Schedule

*Explain any adverse reaction to vaccine(s): _____

Is your child regularly exposed to second-hand smoke? □Yes □No

Has your child ever taken antibiotics? □Yes □No *If yes, explain: _____

Child's current or former medications: _____

Please check each condition that your child now has, or formally had:

□Anxiety □Asthma □Autism □Bed Wetting □Bronchitis □Constipation □Diarrhea

□Difficulty gaining weight □Ear Infections □Headaches □Hyperactivity □Frequent colds/illnesses

□Learning Disability □Physical Pain-list location(s): _____ □Sleeping difficulties □Seizures

□Skin Rashes □UTIs □ Other concerns: _____

_____

Are you aware of any food or juice allergies/intolerances? _____

What activities is your child involved in? _____

Please rate your child's average daily stress level on a scale of 1-10 (10=highest): 1 2 3 4 5 6 7 8 9 10

How does your child do in school? _____

Does your child eliminate stool each day? □Yes □No List your child's typical breakfast: _____

Lunch? _____ Dinner? _____

Snacks? _____ Drinks? _____

-If you are bringing in your child for <u>wellness care</u>, you may skip to GOALS-

Reason For This Visit

Describe your chief reason for bringing your child in for care: _____

When did this condition begin? _____

Has this condition: □Gotten Worse □Stayed Constant □Come & Gone

What life functions does this condition interfere with? _____

What seems to make it worse? _____

What seems to make it better? _____

Have you seen other medical professionals for this condition? □Yes □No

*If yes, Doctor's Name: _____ Type of Treatment _____

Results of Treament: _____

Please describe any additional concerns you want the doctor to know about:

Goals

What changes (if any) in your child's health or behavior would you like accomplished? _____

_____

Please attach any additional documentation you deem relevant for your child' appointment to the back of this paperwork.

I certify that the above information is accurate to the best of my knowledge.

Parent/Guardian Signature: _____ Date: _____

Paren/Guardian Printed Name: _____