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PEDIATRIC INTAKE FORM FOR CHILDREN AGES 9-12

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:

____

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: ____

Describe any genetic conditions your child has been diagnosed with: ____

Has your child ever been hospitalized/had surgery? ☐Yes ☐No *If yes, explain: _________________________________

Any serious physical traumas (falls, car accidents, etc)? ____

Describe any broken bones your child has had: ____

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

*Explain any adverse reaction to vaccine(s):

Child Health History Cont.

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

Child's current or former medications: ____

List any vitamins/supplements your child takes: ____

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

For females: Has your child begun menstruating? □Yes □No *If yes, age of first cycle: ___________________

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

□Anxiety □Asthma □Autism □Bed Wetting □Constipation □Diarrhea □Difficulty gaining weight

□Depression □Difficult/painful/irregular periods □Ear Infections □Headaches □Hyperactivity

□Frequent colds/coughs □Learning Disability □Physical Pain (list location: ___________________________________)

□Sleeping difficulties □Seizures □Skin Rashes □UTIs □ Other concerns:________________________________

____

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? ____

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

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: _______________________________________