Pediatric Patient Intake Form

Patient name: _____ Age: _____ Birth Date: _____/_____/_____

Address: _____ City: _____ State: ____ Zip Code: _____

Name of Parents/Guardians: _____

Parents Home Phone #: _____ Work phone #: _____ Cell Phone #: _____

Email: _____

Referred by: _____

Consultation

Reason for seeking chiropractic care: _____

When did the problem begin: _____

Is this problem □ Occasional □ Frequent □ Constant □ Intermittent □ Other _____

If the pain travels, where does it go? _____

What makes it better? _____

What makes it worse? _____

Is the problem worse during a certain time of day? NO YES If yes, when? _____

Does this interfere with the child's □ Sleep □ Eating □ Daily routine □ Is it becoming worse? NO YES

If yes, how? _____

Other professionals seen for this condition? _____

Results with treatment? _____

Prenatal History for Infants and Newborns

Name of Obstetricians/Midwife: _____

Complications during pregnancy? NO YES If yes, list: _____

Birth Intervention: □ Forceps □ Vaccum □ Caesarian: Planned or Emergency

Complications during delivery? NO YES If yes, list: _____

Medications during pregnancy? NO YES If yes, list: _____

Cigarette/Alcohol use during pregnancy? NO YES

Was the infant alert and responsive within 12 hours of delivery? NO YES

If no, please explain: _____

Birth Weight: _____ Birth Weight: _____

Genetic disorders or disabilities? _____

Breast fed? NO YES How long? _____ Formula fed? NO YES How long? _____

Solid foods at _____ months Cow's milk at_____ months Food/Juice allergies/intolerances NO YES

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

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Medication History

Previous Chiropractor: _____ Date of last visit & reason: _____

Name of Pediatrician: _____ Date of last visit & reason: _____

Are you satisfied with the care your child received? NO YES

Immunization History: _____

Reactions: _____

Medications during pregnancy? NO YES If yes, list: _____

Check ALL drugs your child is taking including prescription and non-prescription drugs:

___ Asthma medication ___ Tylenol ___Advil/Ibuprofen ___ Cold tablets ___Allergy medication

___ ADHD medication ___ Painkillers ___ Anti-depressants ___ Other _____

Does your child take any vitamins or herbs? NO YES If yes, list: _____

Number of antibiotics your child has taken: Past 6 months _____ Total during his/her lifetime _____

Falls & Injuries

When was your child's most recent fall? _____ What happened? _____

_____

Which of the following sports have your child been involved in?

□ Football □ Basketball □ Soccer □ Gymnastics/Cheerleading □ Martial Arts

□ Baseball/Softball □ Hockey □ Running □ Horseback Riding □ Other: _____

Has your child ever broke a bone? NO YES If yes, when & which one? _____

Has your child ever been involved in an auto accident? NO YES Was there impact? NO YES

Were there any injuries? NO YES If yes, dates & any treatment _____

Has your child ever been seen on an emergency basis? NO YES If yes, please list all: _____

_____

Other traumas not described above? NO YES If yes, please explain: _____

Surgeries? NO YES If yes, type & dates: _____

Childhood Diseases & Illnesses

□ Acid Reflux	□ ADD/ADHD	□ Allergies	□ Anemia
□ Arthritis	□ Asthma	□ Autism	□ Backaches
□ Bed Wetting	□ Behavioral Problems	□ Blood Disorders	□ Chronic Colds
□ Bronchitis	□ Colic	□ Chicken Pox	□ Digestive Issues
□ Chronic Ear Aches	□ Diabetes	□ Constipation	□ Fainting
□ Depression	□ Ear Infection	□ Diarrhea	□ Heart Trouble
□ Dizziness	□ Growing Pains	□ Epilepsy	□ Jaundice
□ Fatigue	□ Hyperactivity	□ Headaches	□ Neck Pains
□ Hernias	□ Loss of Smell	□ Hypertension	□ Sinus
□ Loss of Balance	□ Poor Coordination	□ Mumps	□ Urinary Problems
□ Poor Appetite	□ Seizures	□ Recurring Fevers	□ Walking Problems
□ Scoliosis	□ Stomach Aches	□ Shortness of Breath	□ Other:
□ Sore Throats	□ Whooping Cough	□ Temper Tantrums	_____

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Consent to Treat A Minor

I, _____, Parent or Legal Guardian of _____
Your Name (Print) Child's Name

Hereby authorize Pure Wellness doctors and staff to administer chiropractic care to my son or daughter as they deem necessary. As of this date, I have the legal right to select and authorize health care services for the minor child. Under the terms and conditions of my marriage, divorce, separation, or other legal authorization the consent of a spouse/former spouse or other parents is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

Signature of Parent/Guardian _____ Date: _____