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: _______________________________