NEW FRONTIERS
CHIROPRACTIC

PEDIATRIC INTAKE FORM

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 ❑ Nausea/Vomiting
❑ 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 DISEASE, ILLNESS & VACCINATIONS

Has your child had (check all that apply)?:

❑ Chicken Pox ❑ Measles ❑ Robiola

❑ Mumps ❑ Rubella ❑ Pertussis/Whooping Cough

Has your child ever suffered from (check all that apply)?:

❑ Allergies ❑ Broken Bones ❑ Digestive Issues (constipation/diarrhea) ❑ Hypertension ❑ Orthopedic Problems

❑ Anemia ❑ Chronic Ear Aches ❑ Juvenile / Rheumatoid Arthritis ❑ Paralysis

❑ Arm Problems ❑ Colds/Flu ❑ Dizziness ❑ Poor Appetite

❑ Asthma ❑ Colic ❑ Fainting ❑ Joint Problems ❑ Ruptures/Hernias

❑ Back Aches ❑ Convulsions/Seizures ❑ Headaches ❑ Leg Problems ❑ Sinus Trouble

❑ Bed Wetting ❑ Delayed Speech ❑ Heart Trouble ❑ Neck Problems ❑ Tuberculosis

❑ Behavioral Problems ❑ Diabetes ❑ Hyperactivity ❑ Neuritis ❑ Walking Problems

Have you vaccinated your child?

❑ No ❑ Yes ❑ As Scheduled ❑ Delayed Schedule

ALLERGIES, MEDICATIONS, SURGERGIES, & FAMILY HISTORY

ALLERGIES (list)

_____

_____

MEDICATIONS (list)

_____

_____

SURGERIES (list)

_____

_____

FAMILY HISTORY (list)

_____

_____

SIBLINGS

How many children do you have?_____ Number of pregnancies: _____

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

Children's health concerns:_____ 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.

Parent/Guardian Signature: _____ Witnessed: _____ Date: _____

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e. a bed, changing table, down stairs).

Did you child have a fall similar to what was described above? □ Yes □ No

Explain: _____

Has your child been involved in any sports? □ Yes □ No List: _____

Please list all past broken bones, surgeries or hospitalizations: _____

_____

Other traumas not listed: _____

Is there anything else you would like us to know about your child?

_____

FAMILY HISTORY:

Does anyone in your family been diagnoses with: □ Heart Disease □ High Blood Pressure □ Kidney Disease □ Lung Disease □ Diabetes □ High Cholesterol □ Asthma □ Cancer □ Stroke □ Alzheimer's/dementia □ Osteoporosis □ Genetic Disorder

Please list child, spouse, sibling, mother, and/or father and diagnosis: _____

_____

EXPERIENCE WITH CHIROPRACTIC:

Have your child seen a Chiropractor before? □ Yes □ No Reason for visits: _____

Favorable outcomes? □ Yes □ No Explain: _____

Are you aware of any poor posture habits of your child/children? □ Yes □ No Explain: _____

Do you have other children that have not had their spines checked? □ Yes □ No