Pediatric New Patient In-Take Form

PERSONAL HISTORY

Name: _____DOB: _____ Age: _____ Male☐ Female☐

Name of Parent/Guardian: _____ Address_____

City: _____ Prov: _____ PC: _____

Telephone: Home _____ Work: _____Cell: _____

Email address: _____

M.D._____

Has your child ever seen a Chiropractor before? Yes☐ No ☐

Who did he/she see? _____What techniques were used? _____

Has your child ever seen a wellness chiropractor? Yes☐ No☐

Whom may I thank for referring you? _____

Please list any vitamins or medications taken: _____

Surgeries/Hospitalizations:_____

Mother's Health during Pregnancy (smoking, drinking, illness, medications):

_____

Duration of Gestation: _____ Type of Birth (Vaginal, cesarean, induced, forceps)

Birth Injuries/Trauma: _____

_____

Was the child breast or bottle fed? _____ How Long? _____

Does the child have any food allergies? _____

What currently concerns you about your child's health?

1._____

2._____

3._____

Name:_____ Date:_____

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When did these health concerns begin?

_____

_____

What were you told?_____

What was done and did it work? _____

_____

General Physical Trauma:

Please list any injuries, which may have occurred from birth to present. Please include dates of the incidents. Be sure to list any falls, playground accidents, sports injuries, car accidents, broken bones, extensive dental work, and repetitive movements.

_____

_____

_____

List any surgeries your child has had including dates: _____

_____

Chemical History

List any medications (include prescriptive and non-prescriptive) that your child is taking.

_____

How would you rate your child's emotional/mental health?

□ Excellent □ Good □ Fair □ Poor □ Getting better □ Getting worse