ROCK SOLID CHIROPRACTIC

PIN:_____ Date:_____

# Pediatric Intake Form *(5 years and under)*

Child's Name:_____ Date of Birth:_____
Mother's Name:_____ Father's Name: _____
Street Address:_____ City:_____ State ____ Zip Code: _____
Cell: (___)_____-_____ Home: (___)_____-_____ Alternate: (___)_____-_____

## Sibling Information

Name:_____ Age:____ Sex: ___ Name:_____ Age:____ Sex:____
Name:_____ Age:____ Sex: ___ Name:_____ Age:____ Sex:____

## Insurance Information

**Company:_____ ID#: _____ Policy #: _____ Phone:_____**

## Medical Healthcare Provider and/or Clinic Information

Name of Clinic: _____ Dr./P.A.: _____ **Phone:**_____
Street Address:_____ City:_____ State _____ Zip Code: _____
When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? *Please circle preference.* YES NO

## Child's Health History

Your answers to the following questions will help us learn more about your child's health. Please take a few minutes to complete this questionnaire—you may skip any questions you are uncomfortable answering or are not applicable.

What is your child's chief complaint today? *—Check all that apply—*

- ☐ Neck / Back / Joint pain
- ☐ Headaches
- ☐ Depression / Anxiety
- ☐ Respiratory Problems (e.g., asthma, allergies, sinus congestion)
- ☐ Digestive Problems (e.g., poor appetite, heartburn, constipation, diarrhea)
- ☐ Urinary Problems (e.g., difficult or painful urination, kidney stones)
- ☐ Fatigue or low energy
- ☐ Female reproductive health
- ☐ Male reproductive health
- ☐ Stress management
- ☐ General wellness
- ☐ Other(s): _____ _____ _____ _____

Date symptoms appeared or accident happened: _____
Has your child ever had the same or a similar condition? _____ If yes, when and describe:_____
_____
How did it originally occur? _____
Has it become worse recently? *Please circle.* YES NO SAME Better Gradually Worse
If **yes**, include when and how? _____
How frequent is the condition? *Please Circle.* Constant Daily Intermittent Night Only ___
How long does it last? *Please Circle.* All Day Few Hours Minutes
Is there anything you can do to relieve the problem? (*Please Circle)* Yes No If **yes**, describe_____
_____
If no, what have you tried to do that has not helped? _____
_____

Are there any other conditions or symptoms that may be related to your major symptom? (*Please Circle)* Yes No

If **yes**, please check all those which apply below:

- ☐ Complications
- ☐ Medications
- ☐ Recreational drugs
- ☐ Smoking
- ☐ Alcohol
- ☐ Caffeine: Cola
- ☐ Caffeine: Coffee
- ☐ Caffeine: Tea
- ☐ Caffeine: Chocolate
- ☐ Caffeine: Other
- ☐ Vitamins/Minerals
- ☐ Any diagnosed Illnesses
- ☐ Hospitalization
- ☐ Immunization
- ☐ Bleeding
- ☐ Premature Contractions
- ☐ Excessive Weight Gain
- ☐ Toxic Exposures
- ☐ Allergic Reactions
- ☐ Mental Trauma
- ☐ Physical Injury
- ☐ Back Pain
- ☐ Other Pain
- ☐ Excessive Weight Loss
- ☐ Allergic Reactions
- ☐ Prenatal Classes
- ☐ Chiropractic Care
- ☐ Prenatal Care
- ☐ Carried to Full Term
- ☐ Attitude–Mostly Happy
- ☐ Attitude–Mostly Depressed

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## Child's Health History *(continued)*

***Please check any health problems your child <u>is currently or has in past</u>—Answer to the best of your knowledge.***

- ☐ Cancer (malignant or metastatic)
- ☐ Diabetes (Type I or II)
- ☐ Infectious Diseases (e.g. hepatitis, HIV)
- ☐ Heart, Lungs and Circulation (e.g. asthma, heart murmur)
- ☐ Digestive System (e.g. poor appetite, heartburn, constipation, diarrhea)
- ☐ Psychosocial Health (e.g. depression, anxiety,violence toward self or others)
- ☐ Skeleton and joints (e.g. arthritis, back or neck pain)
- ☐ Genitourinary System (e.g. difficult or painful urination, kidney stones, sexually transmitted diseases)
- ☐ Nervous System (e.g. headache, dizziness)
- ☐ Eyes, ears, nose, and throat (e.g. loss of vision or hearing, ear infections, severe dental problems)
- ☐ Skin (e.g. rashes, sores, moles that have changed)
- ☐ Chronic Immune System deficiencies (e.g. colds, sinusitis, bronchitis)
- ☐ Other: _____

## Family Health History

Do/did any members of your immediate family (mother, father, sister, brother) have any serious health conditions?

*Please Circle:* YES NO

Family member's relation to child: _____and their condition: _____

_____

_____

## Pregnancy *Please check any areas that applied to the patient's mother during her pregnancy:*

## Labor and Delivery

- ☐ Greater than 12 Hours
- ☐ Caesarian
- ☐ Complications Hospital
- ☐ Home Birth
- ☐ Medications
- ☐ Premature Delivery
- ☐ Forceps Vacuum Extraction (*Please Circle Applicable Method*)
- ☐ Other_____

## Perinatal History – **If known,** please indicate:

The duration of the pregnancy was ____weeks.
The apgar score at birth was:____
The apgar score at five minutes was:_____
The length at birth was:_____
The birth weight was:_____

*Please check any problems the patient had at birth:*

- ☐ Breathing
- ☐ Coloring
- ☐ Crying
- ☐ Choking
- ☐ Nursing
- ☐ Sleeping
- ☐ Jaundice

*Please check if any item(s) applied to patient at birth:*

- ☐ Medication Surgery
- ☐ Artificial Feeding
- ☐ Erythromyocin
- ☐ Vitamin K
- ☐ Circumcision
- ☐ Other(s):_____

Please provide a complete list of all items listed below or mark "**N/A**," if not applicable. Your child's:

Surgeries: _____ Traumas/Injuries: _____

Allergies:_____

Current medications/dosages: _____

## Nutrition *Please check if the patient has received any of the following items:*

- ☐ Breast Milk
- ☐ Sweets
- ☐ Commercial Formula
- ☐ Juice: Fruit
- ☐ Cow's Milk
- ☐ Vegetable
- ☐ Goat's Milk
- ☐ Vitamins
- ☐ Solid Foods
- ☐ Medications
- ☐ Other *(Please Explain)* _____

## Immunizations

Please list any immunizations the patient has received along with the date it was received and any reactions observed:

_____

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***I,_____(Print Name), hereby declare all information regarding _____(Patient's Name). provided above is accurate, current and complete to the best of my knowledge.***

Signature of Parent/Guardian: _____ Date_____