



# Pediatric Intake Form



Please take a moment to answer the following questions that are designed to maximize your child's health. Many types of stress (physical, mental, chemical) can interfere with your child's growing spine and nervous system. Spinal health is an exciting new concept for many people, so please remember to ask questions.

Date: \_\_\_\_\_

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
Father's Name \_\_\_\_\_ Home Phone# \_\_\_\_\_ Cell# \_\_\_\_\_  
Mother's Name \_\_\_\_\_ Home Phone# \_\_\_\_\_ Cell# \_\_\_\_\_  
Address \_\_\_\_\_

1. Please **Circle** Appropriately: Birth Place: Home/ Hospital/ Birth Center  
Type: Vaginal/ C-section  
Procedures: Forceps/ Vacuum Extraction

2. **Circle** if your child was breast fed or formula fed

3. Please list all sports and activities that your child participates in:  
\_\_\_\_\_

4. According to the National Safety Council, approximately 50% of infants fall head first from a high place (bed, Changing table, etc) during the first year of life. Has this happened to your child? Y/N If So Please explain Briefly  
\_\_\_\_\_  
\_\_\_\_\_

5. Please circle any of the following conditions the your child has suffered from in the last 6 months  
Ear Infection Scoliosis Seizures Chronic Colds Head Aches Asthma/Allergies Digestive Problems ADHD  
Recurring Fevers Colic Bed Wetting Car Accident Growing Pains  
Other \_\_\_\_\_

6. List other doctors you have seen for the above conditions: \_\_\_\_\_

7. In the last year has your child taken or is your child currently taking any prescription **or** over the counter medications? Y/N  
If so please list the name of the medication and the reason for its use:  
\_\_\_\_\_

8. How many prescriptions of antibiotics has your child taken:  
During the past 6 months \_\_\_\_, Total During His/Her Lifetime \_\_\_\_

9. Has your child been fully vaccinated? Y/N

10. Has your child experienced any adverse reactions to the vaccines? Y/N  
If so has the reaction been reported? Y/N  
Please list all reactions of your child and other family members?  
\_\_\_\_\_

11. Please list any and all concerns you have about your child's health.  
\_\_\_\_\_