Child's Intake Form

Child's Name______________________________Age_______ DOB____________ Today's Date _____________
Name of Parents / Guardians____
Address ____ City __________________State _______Zip_________
Home Phone__________________________Other Phone________________________________
Email ____ Number of siblings & ages____________________
Whom may we thank for referring you to us? ____
Reason for seeking chiropractic care**:**____
Have you've been to a chiropractor before?____

Health History

Name of Pediatrician: _________________________________ Date of last visit _______________
Reason for visit: ____________________________________ Medications______________________________
Conditions being treated: ____
Other Doctors seen for this condition Y/N Specialty: ____
Prior treatment and outcome: ____
Has your child ever taken antibiotics? Y/N _________________________________
Has your child been injured participating in contact sports (Soccer, Football, Martial Arts…) Y/N:__________
If yes, please describe ____
Has your child ever been involved in a car accident? Y/N Date & Injuries ______________________________
Has your child ever fallen head first from (Changing Table, Bed, Stairs…) Y/N ________________________
Other traumas not described above? Type & Date: ____
Prior surgery: Type and Date:____
Please describe any emotional traumas____
Chemical exposures and/or allergies:____

Prenatal History

Location of Birth: ___ Home ___ Birthing Center ___ Hospital ___Stepchild ___ Adopted
Complications during pregnancy: Y/N List: ____
Number of ultrasounds during pregnancy? __________
Any medications during pregnancy? ____
Cigarette / Alcohol use during pregnancy: Y/N How much?____
Birth intervention: ______ Forceps _____ Vacuum ____ Caesarian, Why?_______________________________
Complications during delivery?____

Feeding History

Breast Fed: Y/N How long'?__________________ Formula fed: Y/N How long'?____________________
Type:_____________ Introduced to solids at _____ months. Cow's milk at ________ months
Food / juice allergies or intolerances Y/N List: ____

Developmental History

Sleep (Hrs per night) _______ Naps (number & lengths) ____
Problems sleeping ____
At what age was your child able to: Crawl _______Sit_______Stand _______Walk _______Say words ________
Potty trained?_______ Night time accidents? ____

Childhood Diseases and Vaccinations

__ Chicken Pox - Age _____ __ Mumps - Age _____ __ Rubella - Age _____
__ Whooping cough - Age _____ __ Measles - Age _____ __ Meningitis - Age ______
__ Tuberculosis - Age _____ __ Other __________________________ Age _____

Vaccination History:
__ HBV / Hep B (Hepatitis B) – Age ______ __MMR (Measles, Mumps, Rubella) – Age ______
__ DTP or _DTaP (Diphtheria, Tetanus, Pertussis) – Age ___ __Varicella (Chicken Pox) – Age ______
__ HbCV / Hib (H. influenzae type b conjugate) – Age _____ __ PCV (Pneumoccocal) – Age ______
__ OPV (Oral Polio Vaccine) or ___IPV (Inactivated Poliovirus) – Age _____
Adverse Reactions to Any Vaccine? Y/N List: ____
Would you like some information about vaccines? ____

CONSENT TO CHIROPRACTIC CARE
I certify that the information that I have supplied is correct and accurate to the best of my knowledge.
I, ________________________________, being the parent or legal guardian of ___________________________
hereby grant permission for my child to receive chiropractic care.

Signed ____Date _________________________