New Patient Intake Form (Pediatric)

Date: _____

Name: _____ **I prefer to be called:** _____

Mother's Name: _____

Father's Name: _____

Home Address: _____

Phone: _____ **Email:** _____

Age: _____ **Height:** _____ **Weight:** _____

Primary Care Doctor: _____

How did you hear about this office? _____

_____

Has your child seen a chiropractor before? Yes / No

Any preferences as to how you like your child to be adjusted? _____

_____

Chief complaint/reason for visit today: _____

_____

_____

_____

_____

How long has this been going on? _____

Any known inciting event: _____

_____

_____

Have you seen anyone for treatment prior to now: Yes / No

Whom/what treatment: _____

_____

_____

_____

Circle any qualities that describe your child's symptoms:

Numbness / Burning / Stabbing / Aching / Tingling / Tightness / Sharp / Dull / Weak

Grade your child's pain as of right now: (Please circle one: 0 = no pain; 10 = worst pain imaginable)

☺ 0 1 2 3 4 5 6 7 8 9 10 ☹

Does the pain stay in one place or radiate anywhere? Please explain: _____

_____

_____

Do the symptoms seem to be:

getting worse / not changing / getting better

Does anything make the symptoms <u>better</u>? e.g. time of day, position, activity, etc. _____

_____

_____

Does anything make the symptoms <u>worse</u>? e.g. time of day, position, activity, etc. _____

_____

_____

Have you noticed any behavioral changes in your child? e.g. irritability, fatigue, crying, withdrawn, etc._____

_____

HEALTH HISTORY

Circle all varieties of health issues <u>your child</u> currently has or have had in the past:

Cancer / Diabetes / Infectious Diseases / Heart, Lungs, Circulation / Skin / Digestive System / Psychosocial Health / Skeleton and Joints / Urinary / Nervous System / Headaches / Chronic Immune System Deficiencies / Reproductive System / Thyroid / Eyes, Ears, Nose, Throat

Details/Other: _____

_____

_____

_____

Circle any conditions that <u>immediate family members</u> currently have or have had in the past:

Cancer / Diabetes / Stroke / Thyroid Issues / Heart Disease / Psychosocial Health

Details/Other: _____

_____

_____

Please list any traumas/injuries/surgeries and their dates: _____

_____

_____

_____

Has your child ever experienced a concussion? Yes / No

Have your child ever experienced a loss of consciousness? Yes / No

Please list all known allergies: _____

_____

Please list all medications and dietary supplements. Please include dose if known, reason for taking, and prescribing doctor): _____

_____

_____

_____

_____

_____

_____ Please continue on back of page if more space is needed.

Has your child had preventive health screenings for the following (check all that apply):

□ **Well child visit within the last**	□ month	□ 6 months	□ year	□ 5 years	□ 5+years	□ Never
□ **Dental within the last**	□ month	□ 6 months	□ year	□ 5 years	□ 5+years	□ Never

Did the results of any of these (or other) screenings cause concern for you or your doctor?
Please explain: _____

_____

_____

PREGNANCY

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

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

BIRTH

Please check any areas that applied during the birth process:

- □ Labor Greater than 12 hours
- □ Complications
- □ Fetal Monitor Used
- □ Medications
- □ Forceps
- □ Caesarian
- □ Hospital
- □ Home Birth
- □ Premature Delivery
- □ Vacuum Extraction
- □ Other: _____

PERINATAL

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/concerns the patient had at birth:

- □ Breathing
- □ Coloring
- □ Crying
- □ Choking
- □ Nursing
- □ Sleeping
- □ Jaundice
- □ Other: _____

Please check if any items applied to the patient at birth:

- □ Medication
- □ Artificial Feeding
- □ Vitamin K
- □ Surgery
- □ Erythromycin
- □ Circumcision
- □ Other _____

LIFESTYLE

About how many hours of sleep does your child get per night? _____

From what time to what time? _____

Do they seem rested when they wake? Yes / No

Do they have difficulty falling asleep? Yes / No

Do they have difficulty staying asleep? Yes / No

About how many glasses of water does your child drink /day? _____

How would you describe his/her diet overall? _____

_____

Please describe the usual food and drink that the patient consumes for:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Rate your current perception of stress in your child's life:
(Please circle one: 0 = no stress; 10 = unmanageable stress)

☺ 0 1 2 3 4 5 6 7 8 9 10 ☹

Do you feel like your child has adequate support and skills to manage current life stressors? Yes / No

About how many (if any) caffeinated drinks does you consume per day? (and what kind?) __

_____

What physical activity/activities does your child enjoy? _____

_____

_____

On average, how much physical activity has your child gotten over the past month? (Circle one)

None Less than 1x/week 1x/ week 2-3x/ week 4 or 4+x/ week

GOALS/RECOMMENDATIONS

What are your treatment goals/expectations? _____

_____

_____

_____

_____

At this point in time, would you like recommendations for:

Nutritional Support / Postural Exercise / Breathing Exercises / Stress Management / Additional Complementary Services (massage, acupuncture, homeopathy, functional neurology, naturopathic medicine, midwifery, yoga, Pilates, etc.)

Other: _____

_____

ODDS AND ENDS

Is there anything else that you feel is important that I should know about your child? _____

_____

_____

_____

_____

_____

_____

_____