



**Pediatric Intake Form (Birth to 12 years)**

**Patient Information:**

Date: \_\_\_\_\_  
Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Parent / Guardian's Name: \_\_\_\_\_  
Home Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_  
Address: \_\_\_\_\_  
E-mail Address: \_\_\_\_\_  
Has your child been checked by a Doctor of Chiropractic?  Yes  No  
If yes, please provide the name of the office & doctor. \_\_\_\_\_  
Were x-rays taken  Yes  No  
Who is your medical pediatrician? \_\_\_\_\_

**Prenatal History:**

Is your child adopted?  Yes  No  
Did you have any complications and when? \_\_\_\_\_  
Did you smoke?  Yes  No  
Did you consume alcohol?  Yes  No  
Did you take medication?  Yes  No  
Reason for the medication? \_\_\_\_\_

**Birth History:**

Did you have ultrasound during this pregnancy?  Yes  No  
What was the frequency? \_\_\_\_\_  
Place of Birth:  Home  Birthing Center  Hospital  
Provider:  Midwife  OB-Gyn  Other  
Type of Birth:  Vaginal  C-section  
Were pain medications used?  Yes  No  
Was labor induced?  Yes  No  
If yes, why? \_\_\_\_\_  
What position did you deliver in?  Squatting  On back  Other  
Birth Trauma?  Doctor assisted  Twisting and/or Pulling  Vacuum Extraction  Forceps  
Newborn trauma (medical procedures and tests):  
APGAR score: birth \_\_\_\_/10 5-minutes \_\_\_\_/10  Unsure  
Did your child have a misshaped skull / head?  Yes  No  
Were there purple markings on their face?  Yes  No  
Did you breast feed your child?  Yes  No  
Does your child prefer one breast over the other?  Yes  No  
If yes, which side  Right  Left  
Does your child have any food allergies?  Yes  No  
If yes, please list: \_\_\_\_\_  
Has your child been immunized?  Yes  No  
Reason for vaccination?  Informed decision  Recommended  Didn't know I had a choice.  
Did your child have any negative reaction to the vaccinations?  Yes  No  
Were they reported?  Yes  No  
Has your child ever had any surgeries?  Yes  No  
If yes, please elaborate. \_\_\_\_\_  
Has your child been on antibiotics?  Yes  No  
If yes, how often and what for? \_\_\_\_\_  
Is your child currently taking any medication?  Yes  No  
Is your child currently taking any vitamins?  Yes  No

**Baby / Toddler (0-4):**

Have any of the following occurred?

- Fall from a changing table
- Frequent crying spells
- Tumble down stairs
- Involvement in MVA
- Fall out of crib
- Fall off of playground equipment
- Play in a Johnny Jumper
- Frequent ear infections
- Tonsillitis
- Reaction to vaccines
- Frequent fevers
- Frequent diarrhea
- Constipation
- Sleeping problems
- Repeated infections or colds
- Colic
- (+ or -) weight gain
- Other (Please explain): \_\_\_\_\_

**Child (5-12):**

Have any of the following occurred?

- Fall from a tree
- Fall off of a bicycle
- Sports accident
- Car accident
- Stomach pains
- Scoliosis
- Bed wetting
- Fall on playground
- Hyperactivity / Autism
- Learning difficulties
- Asthma
- Allergies
- Leg / Knee pains
- Other (Please explain): \_\_\_\_\_

Which of the above bothers your child the most? \_\_\_\_\_

When did it begin? \_\_\_\_\_

Is it getting worse? \_\_\_\_\_

- Yes
- No

Is the pain:

- Constant
- Intermittent
- Cyclic

Affect on activity?

- Not at all
- Somewhat
- Always

Does your child participate in any of the following?

- Soccer
- Football
- Gymnastics
- Karate
- Hockey
- Lacrosse
- Basketball
- Dance
- Wrestling
- Baseball / Softball
- Volleyball
- Tennis
- Swimming
- Rugby
- Other \_\_\_\_\_

How would you rate your child's diet?  Well balanced  Average  High sugar / processed foods

Does your child consume artificial sweeteners?  Yes  No

Fluoridated water?  Yes  No

Number of hours your child sleeps? \_\_\_\_\_ hours per day

Sleep Quality?  Good  Fair  Poor

\*\*\*\*\*

**Authorization to treat a Minor**

I, \_\_\_\_\_ the undersigning parent/guardian having legal custody/guardianship of - \_\_\_\_\_, a minor, do hereby authorize, request and direct Dr. Palmer and whomever she may designate as assistant to perform in judgment any examination and chiropractic diagnosis or treatment which is deemed necessary.

**Any specific written authorization you provide may be revoked at any time by writing to us at the address provided on the front of this form.**

Patient: \_\_\_\_\_  
*Print Name*

Signature: \_\_\_\_\_  
*Parent / Legal guardian*