CHIROPRACTIC TODAY
Natural Solutions FOR BUSY LIVES

Pediatric Intake Form

PATIENT INFORMATION

Patient's Name: DOB:

Parent/Guardian's Name:

Phone Number:

Address:

Email Address:

Has your child ever been checked by a Chiropractor? Yes No

If yes, were X-rays taken? Yes No

Who is your pediatrician?

PRENATAL HISTORY:

Is your child adopted? Yes No

Did you have any complications during your pregnancy & when?

Did you smoke? Yes No

Did you drink alcohol? Yes No

Did you take medication? Yes No

Reason for medication?

BIRTH HISTORY:

Did you have ultrasounds during this pregnancy? Yes No

Place of Birth: Home Birthing Center Hospital

Provider: Midwife OBGYN Other

Type of Birth: Vaginal C-Section

Were pain medications used? Yes No

Was Labor Induced? Yes No

If yes, please explain:

What position did you deliver in? Back Squatting Other

Birth Trauma: Doctor assisted Twisting &/Or Pulling Vacuum Extraction Forceps

APGAR SCORE: Birth: /10 5-minutes: /10 Unsure

Did you breast feed your child? Yes No

Does your child prefer one breast over the other? Yes No

If yes, which side:

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Does your child have any food allergies? Yes No

If yes, please list:

Has your child received any immunizations? Yes No

If yes, is your child on a routine or modified immunization schedule? Routine Modified

Has your child had any surgeries? Yes No

If yes, please list:

Has your child taken antibiotics? Yes No

If yes, how often & 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
- ◯ Fall out of crib
- ◯ Tonsillitis
- ◯ Constipation
- ◯ Reflux
- ◯ (+ or -) weight gain
- ◯ Frequent crying spells
- ◯ Fall off of playground equipment
- ◯ Reaction to vaccines
- ◯ Sleeping problems
- ◯ Difficulty with latching/feeding
- ◯ Tumble down stairs
- ◯ Frequent fevers
- ◯ Repeated infections
- ◯ Involvement in car accident
- ◯ Frequent ear infections
- ◯ Frequent diarrhea
- ◯ Colic
- ◯ Other:

CHILD (5-14):

- ◯ Major Falls
- ◯ Stomach Pains
- ◯ Hyperactivity
- ◯ Leg/Knee pains
- ◯ Headaches
- ◯ Scoliosis
- ◯ Learning difficulties
- ◯ Sports Injury
- ◯ Bed wetting
- ◯ Asthma
- ◯ Car Accident
- ◯ Allergies
- ◯ Other:

Which of the above bothers your child the most?

When did it start?

Is it getting worse? Yes No

Is the pain: Constant Intermittent

Effect on activity: None Some Always

Does your child participate in any of the following?

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

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How would you rate your child's diet? ☐ Well Balanced ☐ Average ☐ High Sugar/Processed foods

Number of hours your child sleeps per night? _____

AUTHORIZATION TO TREAT A MINOR

I,_____ the undersigning parent/ Guardian having legal custody/guardianship of _____, a minor, do hereby authorize, request and direct Chiropractic Today to perform in judgement any examination and chiropractic diagnosis or treatment which is deemed necessary.

Patient:_____
Print Name

Signature: _____
parent/legal guardian