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Pediatric Intake Form

Child's Name: _____ Date: _____

Birth Date: _____ Gender: Male Female

Address: _____City: _____State: _____Zip: _____

Parent's Name:

_____Cell:_____Home:_____

Siblings (Name and age):

_____

Who referred you to our office?

_____

The Nervous System is the primary system in the body which synchronizes health. The healthy function of every cell, every system, and every organ is dependent upon the integrity of the nervous system. The bones of the skull and vertebrae of the spine house and protect this intricate and delicate system.

From the birth process until the present, events have occurred in your child's life, which may have caused interference and damage to the nervous system. Physical, emotional, and chemical stresses common to our contemporary lifestyles can result in misalignment and harm to the spinal column.

This form will help reveal the causes of Vertebral Subluxation which interfere with the optimal function of your child's nervous system and therefore impair your child's inborn health and well-being.

Has your child been checked by a Doctor of Chiropractic? □ Yes □ No

If yes, who? _____

Did you have an ultrasound during this pregnancy? □ Yes □ No

Frequency _____

Place of birth □ Home □ Birth Center □ Hospital

Type of birth □ Midwife □ OB-GYN □ Other _____

Was labor induced? □ Yes □ No

If yes, why?

_____

What position did you deliver in? □ Squatting □ On Back □ Other _____

Birth Trauma □ Doctor assisted □ Twisting □ Pulling □ Vacuum Extraction □ Forceps

Newborn Trauma (medical procedures and tests)

_____

_____

Did you breast feed your child? □ Yes □ No

How long? _____

According to the National Safety Council approx 50 percent of infants have fallen onto their heads during their first years of life. Another study reveals ¼ million children are injured on playgrounds annually.

Can you recall any such jolts, falls or traumas to your child? □ Yes □ No

Please describe:

_____

_____

How would you rate your child's diet? _____

Does your child consume artificial sweeteners? □ Yes □ No

Does your child consume fluorinated water? □ Yes □ No

Place a check by any of the following conditions your child has suffered from.

□ Colic	□ Irregular Sleeping Patterns	□ Night Terrors	□ Seizures
□ Tantrums	□Repeated Infections or Colds	□ Allergies	□ Asthma
□ Headaches	□ Poor Digestion	□ Ear Infections	□ ADD or ADHD
□ Bed Wetting	□ Learning Disorders	□ Emotional Disorders	
□ Other			

_____

How often has your child been treated with drugs?

_____

Were you informed of their adverse reactions? □ Yes □ No

If it was an antibiotic, was your child cultured for its use? □ Yes □ No

Is your child currently on any medications? (Please list)

_____

_____

Any surgeries? (Please list)

_____

_____

Has your child been vaccinated? □ Yes □ No

Did your pediatrician properly inform you about the benefits / risks of vaccinations? □ Yes □ No