PEDIATRIC INTAKE FORM

(Age 2 years and younger)

It is a pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To help us serve you better, please complete the following. We look forward to working with you to build better health for your family.

Patient Name: _____ SSN: _____

Address: _____ City: _____

State: _____ Zip: _____ Cell Phone: _____

Birth Date: _____/_____/_____ Sex: □ Male □ Female Weight: _____ Height: _____

Name(s) of Parent/Guardian: _____

Referred by: _____

Purpose of visit: ____ _____

Other doctors seen for this condition: □ Yes □ No If yes, doctors' name and prior treatment(s): _____

_____

Other health concerns? _____

Check any of the following conditions your child has suffered from during the past six months:

□ Ear Infections	□ Scoliosis	□ Seizures	□ Chronic colds	□ Headaches
□ Asthma/Allergies	□ Digestive Problems	□ ADHD	□ Recurring fevers	□ Growing/back pains
□ Colic	□ Car Accident	□ Bed Wetting	□Temper Tantrums	□ Other: _____

_____

Family History: _____

Previous Chiropractic Care: □Yes □ No Chiropractor's Name: _____

Date of last visit: _____/_____/_____ Reason: _____

Name of Pediatrician: _____ Phone: _____

Date of last visit: _____/_____/_____ Reason: _____

Are you satisfied with the care your child has received there? □ Yes □ No

Number of doses of antibiotics your child has taken in the last 6 months: _____ Lifetime _____

Number of prescription medications your child has taken in the past 6 months: _____ Lifetime _____

Please list: _____

Vaccination History: _____

Prenatal History

Name of Obstetrician/Midwife: _____

Complications during pregnancy: □ Yes □ No If yes, please list: _____

_____

Ultrasounds during pregnancy: □ Yes □ No Number: _____

Medications during pregnancy: □ Yes □ No If yes, please list: _____

Cigarette/alcohol/drug use during pregnancy: □ Yes □ No If yes, please list: _____

Location of birth: □ Hospital □ Birthing Center □ Home □ Other _____

Birth Intervention: □ Forceps □ Vacuum Extraction □ Caesarian Section: □ Emergency □Planned

Complications during delivery: □ Yes □ No If yes, please explain: _____

Genetic disorders or disabilities: □ Yes □ No If yes, please list: _____

Birth Weight: _____ Birth Length: _____ APGAR Scores: _____, _____

Feeding History

Feeding type: □ Breast fed □ Formula Fed □ How long _____

Introduced to solids at _____ months Cow's milk at _____ months

Food/juice allergies or intolerances: □ Yes □ No If yes, please list: _____

Developmental History

During the following times, your child's spine is most vulnerable to stress and should be routinely checked by a Doctor of Chiropractic for prevention and early detection of vertebral subluxation. At what age was your child able to:

Respond to sound _____
Respond to visual stimuli _____
Hold head up _____
Sit up _____
Cross Crawl _____
Stand alone _____
Walk alone _____

According to the National Safety Council, approximately 50% of children fall head-first from a high place during their first year of life (i.e. a bed, changing table, down-stairs, etc.). Was this the case with your child? □ Yes □ No

Has your child ever been involved in a car accident? □ Yes □ No If yes, when? _____

Has your child ever been seen on an emergency basis? □ Yes □ No If yes, when? _____

Other traumas not described above: □ Yes □ No If yes, please list: _____

Prior surgery? □ Yes □ No If yes, please list: _____

Childhood Diseases

Chicken Pox	□ Yes □ No	Age _____	Mumps	□ Yes □ No	Age _____
Rubella	□ Yes □ No	Age _____	Rubeola	□ Yes □ No	Age _____
Whooping Cough	□ Yes □ No	Age _____	Other	_____	Age _____

Authorization for Care of a Minor

I hereby authorize Hatch Chiropractic and its doctors to administer care to my son/daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office. Insurance information should be provided to the front desk staff. A copy of the drivers' license and insurance card is required to file with your insurance company.

Signature of Parent/Guardian: _____ Date: _____

Printed Name: _____