Pediatric Patient Intake Form

Welcome to ChiroLife Family Wellness. We look forward to working with your family to achieve optimum health. A patient's health is not based on symptoms or lack of symptoms. For instance, a tooth is not considered healthy when it has decay even though there is no pain felt. A dentist checks for these "painless" cavities just as a chiropractor checks for spinal misalignment to maintain optimal health and development. Chiropractic does not cure any disease or treat symptoms alone. Rather, our chiropractic analysis will focus on removing nervous system interference, caused by physical, chemical, and/or emotional stressors, allowing the child's body to properly express health.

To help us serve you better, please complete the following: Date:__________

Child's Name______________________________ D.O.B. _____________ Child's Age________
SSN ________________ Gender: M___ F___
Address________________________________ City/State/Zip____________________________
Parent Name(s)_____________________________ Home phone_________________________
Cell #________________ Work #_________________ Where do you prefer we call?_________
Names & Ages of Siblings____
Parents Email Address_______________________________________
Legal Guardian (if other than parent): ____

How did you hear about our office? Is there someone that we may thank for referring you to our office?

____

Please put a check next to the purpose of your child's visit (mark all that apply):
Crisis Management____ Early Detection of Problems____ Prevention____ Wellness____
Maximizing Normal Growth & Development____ Other____

BIRTH HISTORY

Type of Labor: Easy_____ Moderate_____ Difficult_____ IV Pain Meds_____ Epidural______
Type of Delivery: Vaginal_____ Forceps_____ Suction Cup or Vacuum_____ C-section______
Location: Home_____ Birth Center_____ Hospital_____
Problems During Pregnancy:____
Problems During Labor/Delivery:____
Was child born: Cephalic (head first) ____ Breech (feet first) ____
Problems at Birth: Jaundice (yellow)_____ Cyanosis (blue)_____ Congenital Anomalies_______
Was mother under Chiropractic care during pregnancy? Yes____ No____

VITAL HEALTH INFORMATION

Current Weight:___________ Current Height or Length:__________________
Do you notice any developmental delays with your child? Yes____ No____
If yes, please explain:____

CURRENT HEALTH CHALLENGE

Major____ Minor________________________
When did this problem begin?____
Is this problem: Occasional___ Frequent___ Constant___ Intermittent___
Does problem radiate? Yes___ No___ If Yes, where? ___________________________________
What makes this worse?____
What makes this better?____
Is the problem worse during a certain time of the day? Yes___ No___ If Yes, when?__________
Does this interfere with: School ______ Sleep_____ Eating ______ Daily Routine______
Is this becoming worse? Yes___ No___

Other than today's presenting complaint, please list any and all concerns regarding your child's overall health, if any:____

Often seemingly unrelated symptoms can manifest as other health concerns. Please check if your child has experienced any of these health challenges:

___Headaches
___Learning Disorder
___Behavioral Disorder
___Ear Infections/Pain
___Menstrual problems/cramps
___Muscle cramps
___Seizures
___Breathing problems (Asthma)
___Growing pains
___Dizziness
___Jaw Problems
___Eating Disorder
___Depression
___Bed wetting/urinary problems
___Numbness
___Fainting
___Irritability
___Weakness
___Allergies
___Sinus problems
___Sleeping problems
___Accident Prone
___Colic
___Fatigue
___Constipation
___Diarrhea
___Heartburn
___Neck/Back problems
___Hyperactivity
___Stiffness
___Loss of Concentration
___Frequent Colds/Flu
___Scoliosis/Poor Posture
___Loss of Smell
___Diabetes
___Acne/Rashes
___Loss of Taste
___High Blood Pressure
___Pneumonia
___Ears buzzing
___Vision changes
___Frequent sore throats

Other: ____

How long has your child been living this way? Weeks______ Months______ Years______
Would you like to find the cause of your child's problem(s)? Yes______ No______ Maybe_____
If so, what result would you want for your child?____

How does your child's current health affect his/her daily life? Restricted in daily activities_____
Hindering ability to participate in sports/activities/exercise______ Trouble at school_______
Difficulty interacting with others______ Creates family stress______ Other_________________

Since problems that Chiropractors look for and detect can be related to many types of stressors, the following information is also very important to us:

Has this child ever experienced the following spinal traumas?

__Fall in baby walker	__Fall from bed or couch	__Fall from crib
__Fall off swing	__ Fall off bicycle	__Fall off skateboard or skates
__Fall from high chair	__Fall off slide	__Fall down stairs
__Fall from changing table	__Fall off monkey bars	__Other___________

Any sports played? Y__ N__ If yes, what sport(s)?____________________________________
Any broken bones or injuries? Y__ N__ If yes, please explain____________________________
____
Ever been involved in an auto accident? Y__ N__ If yes, please explain___________________
____
Any hospitalizations or surgeries? Y__ N__ If yes, please explain_________________________
____

Quality of Sleep: Good___ Fair___ Poor___ # of hours of sleep per night______

Was (or is) this child breast-fed? Yes__ No__ If yes, how long? ____________
Formula introduced at what age? ____

CURRENT HABITS

Diet high in? Fruits___ Veggies___ Water___ Pop/Soda/High Sugar Fruit Drink Intake___
White Sugar___ Dairy___ Gluten (flour)___ Processed Foods___
Does your child overall partake in “high” or “low” levels of activity/exercise? High__ Low__
Smoke?___ Drink?___
Excessive use of Television/Computer/Video Games?____

MEDICAL CARE

Pediatrician/Family Doctor:_________________________ City, State:________________
Date of Last Visit:_______________ Reason:____
Vaccinations: all_____ some_____ none_____
Number of antibiotics taken: In the past 6 months_____________During his/her lifetime______
Has your child ever been treated on an emergency basis? Yes____ No_____
If yes, please explain ____
List, if any, current or past **medications**, and why being
taken:____
____

CHIROPRACTIC CARE

Has your child ever received Chiropractic care? Yes__ No__ (If yes, please provide info below)
Dr.'s Name____________________ Reason____________________
Results________________________ Date of last visit_____________

____

______ I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care, fees for professional services rendered will be immediately due and payable. I have been advised and concur, past due accounts will bear interest at 1% per month on the past due balance. I am responsible for costs required to enforce collection of my account including, but not limited to, collection fees, attorney fees and court costs. There is a $35.00 charge for returned checks.

_______ **Cancelation Policy**: Any time you are unable to keep your appointment, we would appreciate a call in advance from you so that we may cancel your appointment and use the appointment time for another patient. Please call the office and we will be happy to schedule another appointment for you. A $40.00 charge will be made for broken appointments unless **24 hours**' notice is given. No Show visits will result in a full visit fee.

CC Holder name _______________________________
Billing Address: _____________________________________ **Zip Code**:_______________

CC # _____________________________________ **Exp:**_________________ **CVV**:______

____ ________________
Signature of Patient or Guardian Date