PEDIATRIC INTAKE FORM

CONTACT INFORMATION

CHILD'S NAME:

FAMILY ADDRESS:

DOB:_____/_____/_____ GENDER: ❒M ❒F AGE _____

MOTHER'S NAME:

MOTHER'S CELL PHONE:

MOTHER'S HOME PHONE:

MOTHER ADDRESS:

MOTHER'S EMAIL:

MOTHER'S WORK PHONE:

POSITION TITLE:

WE CALL YOU BEFORE YOUR APPOINTMENT TO REMIND YOU OF YOUR APPOINTMENT. HOW WOULD YOU LIKE TO BE REMINDED?
(CHECK ALL YOUR CHOICES)
❒TELEPHONE ❒EMAIL ❒TEXT (CELL CARRIER)_____
❒NONE ❒ALL

WE SEND TEXT MESSAGES (I.E., HAPPY BIRTHDAY, HAPPY ANNIVERSARY, ETC.) PLEASE PROVIDE **CELL CARRIER:**

WOULD YOU LIKE TO RECEIVE OUR NEWSLETTER BY EMAIL ❒YES ❒NO

FATHER'S NAME

FATHER'S CELL PHONE

FATHER'S HOME PHONE

FATHER ADDRESS

FATHER'S EMAIL

FATHER'S WORK PHONE

FATHER'S WORK ADDRESS

POSITION TITLE

WE CALL YOU BEFORE YOUR APPOINTMENT TO REMIND YOU OF YOUR APPOINTMENT. HOW WOULD YOU LIKE TO BE REMINDED? (CHECK ALL YOUR CHOICES)

❒TELEPHONE ❒EMAIL ❒TEXT (CELL CARRIER)_____
❒NONE ❒ALL

WE SEND TEXT MESSAGES (I.E., HAPPY BIRTHDAY, HAPPY ANNIVERSARY, ETC.) PLEASE PROVIDE **CELL CARRIER:**

WOULD YOU LIKE TO RECEIVE OUR NEWSLETTER BY EMAIL? ❒ YES ❒ NO

HOW YOU WERE REFERRED

(CHECK ALL THAT APPLY)
❒FRIEND ❒FAMILY ❒SIGN ❒WEBSITE
❒FACEBOOK ❒LINKEDIN ❒BLOG
❒PROMOTION ❒YELP ❒COMMUNITY EVENT
❒NEWSPAPER ❒MARKETING GROUP(S)
❒YELLOW PAGES

WHOM SHOULD WE THANK FOR REFERRING YOU TO OUR OFFICE?

NAME:

REASON FOR THIS VISIT

DESCRIBE THE REASON FOR THIS VISIT:

_____

_____

_____

DESCRIBE THE CIRCUMSTANCES THAT LED UP TO THIS CONDITION:

_____

_____

_____

WHEN DID THIS CONDITION BEGIN?:

HAS THIS CONDITION:
❒GOTTEN WORSE ❒STAYED CONSTANT
❒COMES AND GOES

DOES THIS CONDITION INTERFERE WITH:
❒SLEEP ❒DAILY ROUTINE ❒OTHER ACTIVITIES
(PLEASE EXPLAIN)

_____

_____

HAS THIS CONDITION OCCURRED BEFORE?
❒ YES ❒NO

HAVE YOU SEEN OTHER DOCTORS FOR THIS CONDITION? ❒ YES ❒NO IF ***YES***:

DOCTOR'S NAME:

TYPE OF TREATMENT:

_____

_____

RESULTS:

_____

_____

_____

PEDIATRIC INTAKE FORM

ABOUT THE CHILD

WEIGHT: AT BIRTH_____ CURRENT_____

LENGTH: AT BIRTH_____ CURRENT_____

INFANT FEEDING:

❒BREAST ❒BOTTLE ❒FORMULA
❒OTHER:

IF BREAST FEEDING, DID/ARE YOU EXPERIENCE FEEDING PROBLEMS? ❒YES ❒NO
IF YES, PLEASE EXPLAIN

_____

_____

_____

_____

OF HOURS SLEEP PER NIGHT:

DID/DOES YOUR BABY HAVE COLIC? ❒YES ❒NO

IF YES, WHEN DID IT START?: _____/_____/_____

HOW LONG HAS THE BABY HAD IT? :_____ MOS.

QUALITY OF SLEEP:
❒GOOD ❒FAIR ❒POOR

TYPE OF HEALTH CARE PROFESSIONAL:
❒OBSTETRICIAN ❒MIDWIFE ❒PEDIATRICIAN
❒FAMILY MD

DATE OF LAST VISIT TO MD:_____/_____/_____

HAS YOUR CHILD EVER BEEN TREATED ON AN EMERGENCY BASIS? ❒YES ❒NO

IF YES, PLEASE BRIEFLY DESCRIBE THE REASON FOR THE TREATMENT AND THE TREATMENT RECEIVED:

_____

_____

_____

_____

WHAT AGE DID THE CHILD:

RESPOND TO SOUND? _____ CRAWL?_____

SIT ALONE?_____ HOLD HEAD UP?_____

STAND? _____ WALK ALONE? _____

FOLLOW AN OBJECT WITH HIS/HER EYES?_____

CHILDHOOD DISEASES

❒CHICKEN POX ❒MUMPS ❒MEASLES ❒RUBELLA
❒RUBEOLA ❒WHOOPING COUGH

MOTHER'S PREGNANCY & LABOR

DURING PREGNANCY DID YOU USE:
❒DRUGS ❒MEDICATIONS ❒TOBACCO ❒ALCOHOL
IF YOU USED ANY OF THESE, PLEASE EXPLAIN

_____

_____

_____

DID YOU EXPERIENCE ANY ILLNESS(ES) WHILE PREGNANT?
❒YES ❒NO

IF *YES*, PLEASE EXPLAIN

_____

_____

_____

PROBLEMS DURING PREGNANCY

_____

_____

_____

_____

TYPE OF BIRTH
(WHERE) ❒HOME ❒BIRTHING CENTER ❒HOSPITAL
(HOW) NORMAL ❒VAGINAL ❒FORCEPS ❒BREECH ❒CESAREAN
❒CHEMICALLY INDUCED ❒DOCTOR PULLED OR TWISTED BABY
❒LABOR WAS DOCTOR ASSISTED ❒VACUUM EXTRACTION
❒PREMATURE DELIVERY

IF THERE WERE PROBLEMS DURING LABOR/DELIVERY (PLEASE EXPLAIN):

_____

_____

_____

_____

APGAR SCORES:

WAS THERE PRESENCE AT BIRTH OF:
❒JAUNDICE (YELLOW) ❒CYANOSIS (BLUE) ❒ CONGENITAL ANOMALIES ❒DEFECTS ❒OTHER (PLEASE EXPLAIN):

_____

_____

_____

_____

CHIROPRACTIC EXPERIENCE

HAVE YOU (THE PARENT(S)) BEEN ADJUSTED BY A CHIROPRACTOR BEFORE? ❒YES ❒NO

IF YES, WHAT WAS THE REASON FOR THE VISIT?

_____

_____

_____

_____

WAS THE CHIROPRACTOR ABLE TO HELP YOU? ❒YES ❒NO

WHAT TYPE OF EXPERIENCE WAS IT FOR YOU? ❒POSITIVE ❒NEGATIVE (PLEASE EXPLAIN)

_____

_____

_____

_____

HAS THE CHILD BEEN ADJUSTED BY A CHIROPRACTOR BEFORE? ❒YES ❒NO

IF YES, WHAT WAS THE REASON FOR THE VISIT?

_____

_____

_____

WAS THE CHIROPRACTOR ABLE TO HELP YOU? ❒YES ❒NO

WHAT TYPE OF EXPERIENCE WAS IT FOR YOU? ❒POSITIVE ❒NEGATIVE (PLEASE EXPLAIN)

_____

_____

_____

_____

VACCINATIONS

HAVE YOU CHOSEN TO VACCINATE YOUR CHILD? ❒YES ❒NO

IF YES, CHECK ALL OF THE VACCINATIONS THAT YOUR CHILD HAS RECEIVED: ❒DPT ❒MMR ❒CHICKEN ❒POX ❒HEPATITIS ❒OTHER

DESCRIBE ANY AND ALL REACTIONS TO VACCINE(S)

_____

_____

_____

_____

CHILD'S HEALTH HISTORY

INSTRUCTIONS: PLEASE CHECK EACH OF THE DISEASES OR CONDITIONS THAT YOUR CHILD CURRENTLY HAS OR HAS HAD IN THE PAST. WHILE THEY MAY SEEM UNRELATED TO THE PURPOSE OF THE APPOINTMENT, THEY CAN AFFECT THE OVERALL DIAGNOSIS, CARE PLAN AND THE POSSIBILITY OF BEING ACCEPTED FOR CARE.

❒ALLERGIES ❒ANEMIA ❒ARM PROBLEMS

❒ARTHRITIS ❒ASTHMA

❒ATTENTION PROBLEMS ❒BACKACHES

❒BED WETTING ❒BEHAVIORAL PROBLEMS

❒BREATHING PROBLEMS ❒BROKEN BONES

❒CHRONIC EARACHES ❒COLDS/FLU (FREQUENT)

❒COLIC ❒CONSTIPATION ❒CONVULSIONS

❒DIABETES ❒DIARRHEA

❒DIGESTIVE PROBLEMS ❒DIZZINESS

❒EAR PROBLEMS

❒FAINTING ❒FREQUENT COLDS

❒"GROWING PAINS" ❒HEADACHES

❒HEART TROUBLE ❒HYPERACTIVITY

❒HYPERTENSION ❒IRRITABILITY

❒JOINT PROBLEMS ❒LEG PROBLEMS

❒MUSCLE JERKING

❒NECK PROBLEMS ❒NEURITIS

❒ORTHOPEDIC PROBLEMS

❒PARALYSIS ❒POOR APPETITE

❒RHEUMATIC FEVER ❒RUPTURES ❒HERNIAS

❒SINUS TROUBLE ❒SKIN PROBLEMS

❒SLEEPING DISORDERS

❒SUGAR CONCENTRATION ❒TUBERCULOSIS

❒TUBES IN THE EARS ❒VISION PROBLEMS

❒WALKING PROBLEMS

❒OTHER: _____

PEDIATRIC INTAKE FORM

CHILD'S CURRENT HEALTH STATUS

NO. OF HOURS SLEEP PER NIGHT: _____ QUALITY OF SLEEP: ❒GOOD ❒FAIR ❒POOR

TYPE OF PERSON PROVIDING CARE FOR YOUR CHILD: ❒OBSTETRICIAN ❒MIDWIFE ❒PEDIATRICIAN ❒FAMILY MD

HAS YOUR CHILD EVER TAKEN ANTIBIOTICS ❒YES ❒NO PLEASE EXPLAIN: _____ _____	HAS YOUR CHILD EVER BEEN HOSPITALIZED? ❒YES ❒NO PLEASE EXPLAIN: _____ _____
HAS YOUR CHILD EVER HAD A SEVERE FALL? ❒YES ❒NO PLEASE EXPLAIN: _____ _____	HAS YOUR CHILD EVER BEEN IN A CAR ACCIDENT? ❒YES ❒NO PLEASE EXPLAIN: _____ _____
IS YOUR CHILD ACCIDENT-PRONE? ❒YES ❒NO PLEASE EXPLAIN: _____ _____	HAS YOUR CHILD EVER HAD SURGERY? ❒YES ❒NO PLEASE EXPLAIN: _____ _____
IS YOUR CHILD CURRENTLY TAKING MEDICATIONS? ❒YES ❒NO PLEASE EXPLAIN: _____ _____	DOES YOUR CHILD HAVE DIFFICULTY INTERACTING WITH OTHERS? ❒YES ❒NO PLEASE EXPLAIN: _____ _____
HAVE YOU OR ANYONE ELSE NOTICED THAT YOUR CHILD IS NERVOUS, TWITCHES, SHAKES OR EXHIBITS ROCKING BEHAVIOR? ❒YES ❒NO PLEASE EXPLAIN: _____	WHAT CHANGES (IF ANY) IN YOUR CHILD'S HEALTH OR BEHAVIOR WOULD YOU LIKE ACCOMPLISHED? PLEASE EXPLAIN: _____

CHIROPRACTIC AWARENESS

DOCTORS OF CHIROPRACTIC WORK WITH THE NERVOUS SYSTEM? ❒YES ❒NO	THE NERVOUS SYSTEM CONTROLS ALL BODILY FUNCTIONS AND SYSTEMS? ❒YES ❒NO
CHIROPRACTIC IS THE LARGEST NATURAL HEALING PROFESSION IN THE WORLD? ❒YES ❒NO	IF CHIROPRACTIC CARE STARTS AT BIRTH, YOU CAN ACHIEVE A HIGHER LEVEL OF HEALTH THROUGHOUT LIFE? ❒YES ❒NO

CONSENT TO TREATMENT OF A MINOR

I (WE), BEING THE PARENT/GUARDIAN OF _____<<CHILD'S NAME>>,

A MINOR, THE AGE OF _____, DO HEREBY CONSENT, AUTHORIZE AND REQUEST THE DOCTORS OF COMPREHENSIVE HEALTH AND CHIROPRACTIC CENTRE, TO ADMINISTER SUCH TREATMENT DEEMED ADVISABLE, NECESSARY OR REQUESTED ON AND FOR THE ABOVE MINOR.

CHCC AGREEMENT

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

I agree to notify this doctor immediately whenever I have changes in my health condition(s) in the future.

I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered to me will be immediately due and payable.

I understand that in the case of default on my part, that necessitates Comprehensive Health and Chiropractic Centre or its agents to employ legal and/or collections counsel, I am responsible for collection charges incurred. These charges will be added to my bill.

Should I be unable to meet the terms of this agreement at any time, I agree to notify the office immediately.

_____ _____/_____/_____

Patient Signature **Date**

_____ _____/_____/_____

Parent or Guardian Signature (if patient is minor) **Date**

_____ _____/_____/_____

Staff Signature **Date**