Adjust Chiropractic
1258 Washington Road
Thomson, GA 30824
Ph (706) 597-0059 Fx (706) 597-9100

Pediatric Intake Form

Patient Information

Child's Name: _____ Today's Date: _____

Parents'/Guardians' Names: _____

Home Address: _____

Home Phone: _____

Parent's Cell Phone: _____

Parent's Work Phone: _____

Parent's Email: _____

How did you hear about us? _____

Child's height: _____ Child's weight: _____ Date of Birth: _____ Age: _____ Sex: ☐ M ☐ F

Previous Chiropractic Care? ☐ No ☐ Yes

Emergency Contact

Name: _____ Relationship to child: _____

Phone number(s): _____ Email: _____

_____

Medical Contact

Pediatrician: _____ Pediatrician's Phone #: _____

Medical Office Name: _____

Medical Office Address: _____

Other Health Care Professionals (Specialist, Naturopathic, Homeopathic Doctors, Physical Therapist, Massage Therapist, Dentist)

Name: _____

Professional Designation: _____

Name: _____

Professional Designation: _____

Name: _____

Professional Designation: _____

Parent's/Legal Guardian's Signature: _____ Today's Date: _____

Child's name: _____ Today's Date: _____

Has your child experienced any of the following? Circle "C" for Current and "P" for Past

C	P	Asthma	C	P	Frequent Diarrhea	C	P	Failure to thrive/Slow Weight Gain
C	P	Respiratory Infections	C	P	Constipation	C	P	Slow or Absent Reflexes
C	P	Sinus Problems	C	P	Flatulence	C	P	Asymmetrical Crawling or Gait
C	P	Ear Infections	C	P	Headaches/Migraines	C	P	Weight Challenges
C	P	Tonsillitis	C	P	Neck Pain	C	P	Bed Wetting
C	P	Strep Throat	C	P	Torticollis/Head Tilt	C	P	Sleep Problems
C	P	Frequent Colds	C	P	Regression of Milestones	C	P	Night Terrors
C	P	Recurrent Fevers	C	P	Back Pain	C	P	Tip Toe Walking
C	P	Eczema	C	P	Growing Pains	C	P	Trouble Feeding on 1 Side/Trouble Latching
C	P	Rashes	C	P	Scoliosis	C	P	Seizures
C	P	Allergies	C	P	Red, Swollen, Painful Joint	C	P	Tremors/Shaking
C	P	Food Sensitivities	C	P	Colic	C	P	ADD/ADHD
C	P	Digestive Problems	C	P	Frequent Crying Spells	C	p	Autism/PPD

What brings you in? _____

When did this start? _____ Is it getting better, worse, or the same? _____

Is this a recurring complaint? ☐ No ☐ Yes _____

Was there an accident or injury involved? If so, describe: _____

_____

Has your child had other treatment for this? If so, what? Did it help? _____

_____

Current Medications: _____

Has your child had x-rays (or other imaging) for this complaint? ☐ No ☐ Yes _____

Prenatal History and Birth Experience

☐ Adopted ☐ Prenatal History Unknown ☐ Birth History Unknown

Any pregnancy complications? ☐ No ☐ Yes Explain: _____

Medications during pregnancy (please include any OTCs)? ☐ No ☐ Yes

If so, which ones and how often? _____

Exposure to alcohol, cigarette smoke, or second hand smoke during pregnancy? ☐ No ☐ Yes _____

Medications, including IV antibiotics, during labor/delivery? ☐ No ☐ Yes _____

Was your labor induced with Pitocin? ☐ No ☐ Yes _____

At any time was your child in a Breech, Transverse, or Face/Brow presentation position? ☐ No ☐ Yes

If so, explain _____

Did you give birth vaginally or by C-section? _____ If by C-section, was it planned or emergency? _____

If it was vaginal, was the baby presented: ☐ Head ☐ Face ☐ Breech

Birth Intervention: ☐ Forceps ☐ Vacuum ☐ Other _____

Parent's/Legal Guardian's Signature: _____ **Today's Date:** _____

Child's Name: Child's name: _____ Today's Date: _____

Delivery Complications? ☐ No ☐ Yes Please explain _____

Was the baby born with any bruising or markings on their face or head? ☐ No ☐ Yes _____

Misshapen head at birth? ☐ No ☐ Yes

Post Natal & Infant History

How many weeks gestation was the baby at birth? ____ w ____ d / Birth Weight: ____ lbs ____ oz / Birth Length: ____ inches

Did your baby have to go into Neonatal Intensive Care? ☐ No ☐ Yes For how long? Reason?: _____

_____

Any medications given to the baby at birth? ☐ No ☐ Not sure ☐ Yes

If yes, what kind and why? _____

How long (hours) is your baby sleeping between feedings? Day _____ Night _____

Do they have a preferred sleeping position? ☐ No ☐ Yes Explain: _____

Did/do you practice attachment parenting methods (co-sleeping, feeding on demand, extended breastfeeding, kangaroo care, elimination communication, etc)? ☐ No ☐ Yes How so? _____

Is/Was your child breast fed? ☐ Yes, exclusively breastfed ☐ Supplemented with formula ☐ No

If yes, how long did you breastfeed? _____ weeks/ months Does your child have a breast preference side? If so, L or R?

____

If formula fed, did they show any sensitivities (reflux, eczema, arching back, etc)? Explain: _____

Does your child frequently spit up after feeding? ☐ No ☐ Yes

Does your child have any difficulty feeding? ☐ No ☐ Yes Explain: _____

Any noticeable sensitivities to foods in your diet or theirs? ☐ No ☐ Yes To What? _____

Exposure to cow's milk/dairy? ☐ No ☐ Yes ☐ Yes, directly ☐ Yes, I drink it and breastfeed

Did you introduce grain or cereal to your child in their first year? ☐ No ☐ Yes

Age you introduced solid foods? ☐ N/A ☐ _____ months

Does your child?: ☐ Cry often? # of hours/day? ____ ☐ Arch head and neck back ☐ Pass excessive gas

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

Describe: _____

Has your child been/had?: ☐ In a car accident ☐ Seen for an emergency ☐ Broken any bones
☐ Other hospitalizations ☐ Previous surgeries

Please describe: _____

_____

Parent's/Legal Guardian's Signature: _____ Today's Date: _____

Child's Name: Child's name: _____ Today's Date: _____

Other Information

Is your child vaccinated? ☐ No ☐ Yes, on a delayed or selective schedule ☐ Yes, on schedule

Reason for vaccination? ☐ Informed decision ☐ Didn't know I had a choice ☐ It was recommended

Any vaccine reactions? ☐ Fever ☐ Welt at injection site ☐ Rash ☐ Diarrhea
☐ Fatigue ☐ Prolonged Crying ☐ Regressed Development
☐ Seizures ☐ Other _____

Annual flu shots? ☐ No ☐ Yes (informed decision) ☐ Yes (recommended by MD)

Taken antibiotics? ☐ No ☐ Yes # times in the past 6 mos? _____ Reason? _____

Did they take probiotics with the antibiotics? ☐ No ☐ Yes

Other/over the counter (OTC) meds? ☐ No ☐ Yes _____

# of times in the past 6 mos? Reason(s)? _____

How much water does your child drink daily? ☐ 0 ☐ 1-3 ☐ 4-6 ☐ 7-9 ☐ 10+

glasses of cow's milk, juice, soda / day? ☐ 0 ☐ 1-3 ☐ 4-6 ☐ 7-9 ☐ 10+

Does your child eat the following? ☐ Boxed/Frozen/Processed foods ☐ Dairy
☐ Refined sugars (sweets, white bread, pasta) ☐ Gluten
☐ Artificial Sweeteners ☐ Organic Foods

Any food/drink allergies, sensitivities, intolerances? ☐ No ☐ Yes _____

Any other dietary restrictions? ☐ No ☐ Yes _____

Exposure to second hand smoke? ☐ No ☐ Yes _____

Take any vitamins or supplements? ☐ No ☐ Yes (please list all) _____

Do you feel like your child is developmentally appropriate for their age? ☐ Yes ☐ No _____

Use of tablet, computer, or video games? ☐ Never ☐ Rarely ☐ Daily ☐ Several hrs/day

TV time? ☐ Never ☐ Rarely ☐ Daily ☐ Several hrs/day

Exercise time? ☐ Never ☐ Rarely ☐ Daily ☐ Several hrs/day

Sports? Which one(s)? _____ ☐ No ☐ Daily ☐ Weekly ☐ Seasonall

Favorite sleeping position? ☐ Back ☐ Belly ☐ R Side ☐ L Side ☐ Both sides

Does your child's backpack weigh more than 15% of their body weight? ☐ No ☐ Yes

Do they wear their backpack on both shoulders? ☐ No ☐ Yes ☐ Sometimes

Does your child show excessive or uneven shoe wearing? ☐ No ☐ Yes

Does your child wear custom orthotics? ☐ No ☐ Yes If so, why? _____

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Authorization to Treat Your Minor

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

By law, any child under the age of 18 years old cannot be seen by a doctor of chiropractic without consent from a parent or legal guardian. If the minor arrives with someone other than a parent or legal guardian, we must have written permission from the parent or legal guardian that this person has been appointed by you to act on your behalf.

You may appoint someone who is over the age of 18 years of age to be responsible for your child when you are unable to accompany them to their chiropractic appointment.

For occasions when you may not be with your child, please list those individuals who may give us consent to treat your child.

_____ _____
Name Relationship to Parent

_____ _____
Name Relationship to Parent

_____ I give consent for this minor to receive chiropractic care without an accompanying adult, which shall be in effect, until revoked by written consent.

It is the policy of this office that the adult presenting the child for treatment, or the child if they are seen without an adult present, is responsible for payment of the patient portion at the time of service. I have read, understand, and give my consent as stipulated above. My signature means that I have read this form and/or have had it read to me and explained in a language that I can understand.

_____ _____
Parent's/Legal Guardian's Printed Name **Parent's/Legal Guardian's Signature**

_____ _____
Date: **Relationship to Patient**