



# GODFREY CHIROPRACTIC & WELLNESS

119 6<sup>th</sup> Avenue East  
Alexandria, MN 56308  
(320) 762-8185  
chiorlife@gmail.com

**PEDIATRIC INTAKE**  
Infants- School Aged Children

## PATIENT INFORMATION

Child's Name: \_\_\_\_\_ Parent/Guardian Name: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip: \_\_\_\_\_

Gender:  Male  Female D.O.B: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Age \_\_\_\_\_

Current Height: \_\_\_\_\_ Current Weight: \_\_\_\_\_

Parents Email: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Cell Provider: \_\_\_\_\_  Yes! I want text appt reminders!

How did you hear about us? \_\_\_\_\_

Has your child been adjusted by a chiropractor before?  YES  NO

If yes, reason for those visits: \_\_\_\_\_ When was the last visit? \_\_\_\_\_

Is your child currently receiving care from other health professionals?

YES  NO If yes, list name and specialty: \_\_\_\_\_

Who is your families primary care physician? \_\_\_\_\_ Contact info: \_\_\_\_\_

## HEALTH HISTORY

Describe the health concern that prompted this visit: \_\_\_\_\_

When did this concern begin? \_\_\_\_\_ How did this concern begin? \_\_\_\_\_

Has this condition:  Worsened  Stayed the same  Been Intermittent  Does  
this interfere with:  School  Sleep  Daily Routine

What makes this condition worse? \_\_\_\_\_

What makes this condition better? \_\_\_\_\_

Has your child seen anyone else for this concern?  YES  NO Type of treatment: \_\_\_\_\_

Please list any medications your child is currently taking + dosage (including OTC): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**BIRTH INFORMATION**

Child's birth was at:  Home  Birthing Center

Hospital

OB/Midwife/Physician

was: \_\_\_\_\_

Child birth was:  Natural vaginal with no medications

Vaginal with interventions:  Pitocin  Epidural  Pain Medications

Vacuum Extraction  Forceps  IV antibiotics

Other: \_\_\_\_\_

C-Section:  Scheduled  Emergency

Adopted  Prenatal history unknown  Birth history unknown

Was your child at anytime during your pregnancy in a constrained position?:  YES  NO  UNSURE

If yes, please describe:  Breech  Transverse  Face/Brow presentation

Complications during pregnancy:  YES  NO (If yes, describe) \_\_\_\_\_

Medications during pregnancy:  YES  NO (If yes, describe) \_\_\_\_\_

If so, which ones and how often? (include OTC): \_\_\_\_\_

Exposure to drugs, alcohol, cigarettes, or second hand smoke during pregnancy:

YES  NO (If yes, describe) \_\_\_\_\_

Birth Weight: \_\_\_\_\_ lbs \_\_\_\_\_ oz Birth Height: \_\_\_\_\_

**TRAUMAS/INJURY**

Please list all hospitalizations and surgical history (include year): \_\_\_\_\_

Please list any major injuries, accidents, falls and/or fractures you child has sustained in his/her lifetime:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The human body is designed to be healthy! The primary system in the body, which coordinates health and function, is the nervous system. Your nervous system is surrounded and protected by the bones of the spine, called vertebrae. Many of the common health challenges that adults experience have their origins during the developmental years, starting at birth. Layers of damage to the spine and nervous system occur as a result of various traumas, toxins, and emotional stress. The result may be misalignment to the spinal column and damage to the nervous system – a condition called Vertebral Subluxation. Please answer the following questions to give us a better understanding about your child's state of wellness and factors which may be contributing to vertebral subluxation and *impeding your child's ability to heal*.

**What signals has your child's body been communicating?**

CURRENT  
PREVIOUS

Asthma

Thrive / Slow Weight Gain

- Respiratory Tract Infections
- Sinus Problems
- Ear Infections
- Tonsillitis
- Strep Throat
- Frequent Colds/Croup
- Recurrent Fevers
- Eczema
- Rashes
- Allergies
- Food Sensitivities
- Digestive Problems

CURRENT  
PREVIOUS

Frequent Diarrhea

- Constipation
- Flatulence
- Headaches/Migraines
- Neck Pain
- Torticollis/Head Tilt
- Trouble Nursing
- Back Pain
- Growing Pains
- Scoliosis
- Red, Swollen, Painful Joints
- Colic
- Frequent Crying Spells

CURRENT  
PREVIOUS

Failure to

- Slow or Absent Refluxes
- Asymmetrical Crawling or Gait
- Weight Challenges
- Bed Wetting
- Sleeping Problems
- Night Terrors
- Tip Toe Walking
- Sensory Processing Issues
- Seizures
- Tremors / Shaking
- ADD / ADHD
- Autism

Other: \_\_\_\_\_

**What is your primary goal for your child at our clinic?**

---



---

Our goal is to provide a detailed assessment of your child's current health status and provide you with the resources for a highly engaged and healthy child whose body is functioning at its absolute peak potential while they grow. Essential to this healthy growth is a properly functioning nervous system that is able to function free from interference called subluxation.

**WRITTEN CONSENT FOR A CHILD**

Name of patient who is a minor/child: \_\_\_\_\_

**I authorize the doctors and staff of Godfrey Chiropractic and Wellness to perform diagnostic procedures, radiographic evaluation, chiropractic adjustments, and to render chiropractic care to my minor/child.**

**As of this date, I have the legal right to select and authorize health care services for my minor/child. If my authority to select and authorize care is revoked or altered in any way, I will immediately notify Godfrey Chiropractic and Wellness.**

Date: \_\_\_\_\_

Guardian Signature: \_\_\_\_\_

WITNESS: \_\_\_\_\_

RELATIONSHIP TO MINOR: \_\_\_\_\_