GODFREY CHIROPRACTIC & WELLNESS

119 6th Avenue East
Alexandria, MN 56308

(320) 762-8185

godfreychiroinfo@gmail.com

PRDIATRIC 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	CURRENT PREVIOUS	CURRENT PREVIOUS
☐ ☐Asthma	☐ ☐Frequent Diarrhea	☐ ☐Failure to Thrive / Slow Weight Gain
☐ ☐Respiratory Tract Infections	☐ ☐Constipation	☐ ☐Slow or Absent Refluxes
☐ ☐Sinus Problems	☐ ☐Flatulence	☐ ☐Asymmetrical Crawling or Gait
☐ ☐Ear Infections	☐ ☐Headaches/Migraines	☐ ☐Weight Challenges
☐ ☐Tonsillitis	☐ ☐Neck Pain	☐ ☐Bed Wetting
☐ ☐Strep Throat	☐ ☐Torticollis/Head Tilt	☐ ☐Sleeping Problems
☐ ☐Frequent Colds/Croup	☐ ☐Trouble Nursing	☐ ☐Night Terrors
☐ ☐Recurrent Fevers	☐ ☐Back Pain	☐ ☐Tip Toe Walking
☐ ☐Eczema	☐ ☐Growing Pains	☐ ☐Sensory Processing Issues
☐ ☐Rashes	☐ ☐Scoliosis	☐ ☐Seizures
☐ ☐Allergies	☐ ☐Red, Swollen, Painful Joints	☐ ☐Tremors / Shaking
☐ ☐Food Sensitivities	☐ ☐Colic	☐ ☐ADD / ADHD
☐ ☐Digestive Problems	☐ ☐Frequent Crying Spells	☐ ☐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:_____