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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		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:____________________