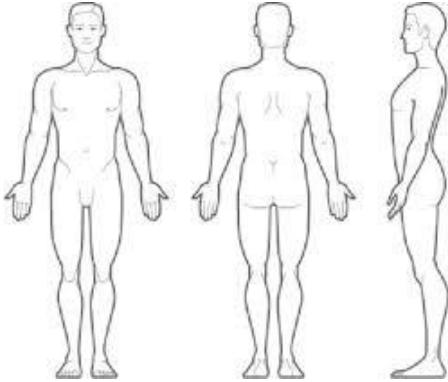
PEDIATRIC PATIENT INTAKE

Child's Name: Date of Birth: Age: Date:
Current Address: Gender at Birth: Male / Female
City: State: Zip:
Primary Phone #: Accept Text: Yes / No Alternate Phone #:
Email:
FAMILY INFORMATION
Mother's Name: DOB: / / Father's Name: DOB: / /
Does one or both parents have custody:
Parent's Marital Status: Married / Single / Divorced / Widowed
List ages of other children in family:
Emergency Contact: Relationship: Phone #:
Whom may we thank for referring you?
HISTORY
Has your child ever received chiropractic care? Yes / No If Yes, when?
Primary reason for seeking chiropractic care:
Chief complaint: When did it begin:
Is this condition getting progressively worse? Yes / No / Unknown
What treatment have you already received for your condition? Medications / Surgery / Physical Therapy / Chiropractic Services / None / Other: _____________
Did you choose to vaccinate your child? Yes / No Full Schedule / Reduced Schedule / Homeopathic Vaccines Date of last vaccination:
Did you notice any changes in your child after their vaccinations? Yes / No If yes, what? ☐ Fever ☐ Inconsolable crying ☐ Irritability ☐ Lethargy/fatigue ☐ Aching ☐ Drowsiness ☐ Bowel Disturbances ☐ Feeding Disturbances ☐ Other: ____________________
Was this child born at home? Yes / No Were forceps or a vacuum extractor used?
C-Section Delivery? Yes/ No Breech: Yes / No
How many courses of antibiotics has your child received in their lifetime?
When was the last course taken and why?
Pets in the home? ☐ Yes / ☐ No Smokers in the home? ☐ Yes / ☐ No
Do you have a family history of: Heart Trouble? Yes / No Cancer? Yes / No Nervous Conditions? Yes/ No Depression: Yes / No Inherited Disease: Yes / No
Please list any/all Vitamins/ Medications currently taking:
Any known Allergies:
DEVELOPMENT HISTORY
Can your child sit unsupported? Yes / No
Is your child crawling yet? Yes / No Is your child walking? Yes / No At what age did they start? _______
Have you noticed a foot turned in or out?
Any other development concerns?
What is his/her favorite food? What food does she/he dislike?
Any problems with bed-time? What sleeping position do they like? Hours total:
Any traumas resulting in bruises, cuts, stitches or fractures? Yes/ No Explain:
Does your child play sports/ exercise regularly? Yes / No Hours per week:
At what age did your child begin sports/exercise regularly?
Do you feel that your child struggles to carry/wear their backpack? Yes / No
Rate your child's posture: Poor 1 2 3 4 5 6 7 8 9 10 Excellent

PEDIATRIC PATIENT INTAKE

YOUR CHILD'S SYMPTOMS
(Many parents bring their children to our practice to enhance wellness. If your child has no symptoms or complaints, please skip this portion)



Mark an X on the picture where you continue to have pain, numbness, or tingling . Please describe type of pain: _____________________
Rate the severity of your pain on a scale from 1 (Least) to 10 (Most Severe) _________
Does this complaint/pain radiate or travel (shoot) to any areas of your body? Where? ___________
Do you have any numbness or tingling in your body? Where? _________
Does it interfere with your: Sleep / Daily Routine / Recreation
Activities that are painful to perform: Sitting / Walking / Bending / Standing/ Lying down

SYMPTOMS	Currently	In Past		Currently	In Past
Low Back pain			Hyperactivity		
Neck pain			Bloody Noses		
Digestive Troubles			Meningitis		
Asthma			Diarrhea		
Headaches			Constipation		
Allergies			Bed Wetting		
Sleeping Disorders			Rashes		
Cold/Flu			Milk/Lactose Intolerance		
Ear/Throat Infections			Sinus problems		
Breathing Problems			Loss of hearing		
Fatigue			Learning disorders		
Irritability			Other_______________		

FINANCIAL INFORMATION

Who is responsible for this account? Relationship to patient:

Is condition due to an accident? Yes / No Type of accident: Auto / Work / Home / Other

Name of Primary Insurance:

Policy Holder Name: Policy Holder DOB: Relationship

Name of Secondary Insurance:

Policy Holder Name: Policy Holder DOB: Relationship:

There are many concerns about the safety of procedures we undergo routinely, the environment we live in, and the food we consume to name a few. We hope to explain some of the risks and common responses to chiropractic care so that any concerns on these matters may be eased. We hope that having a better understanding of the care you will receive at Active Family Chiropractic will enhance your experience. Most people will experience some level of discomfort in the early stages of care. This is due to the change in the pattern of the nervous system. It is a normal response during the initial phase of care. If at any stage of your care you have concerns, doubts or questions we encourage you to discuss these matters with your practitioner.

Being the parent or legal guardian of this child, I hereby authorize Dr. Stephanie Hoglund to examine and administer care to my child as the doctor deems necessary. I understand and agree that I am personally responsible for payment of all fees charged by this office for such care.

Signature of guardian: Date:

Guardian Name (Printed):