RODROCK CHIROPRACTIC

Pediatric Intake Form (Infant- 10 yr)

Today's Date: [Date]	Age of Patient:	Male ○ Female ○

PATIENT INFORMATION

Patient's name:	Parent/ Guardian Name(s):	
Address: [Address/ P.O Box, City, ST ZIP Code]		
Patient's Social Security no.:	Home phone no.:	Cell phone:
Work phone:	Email:	Patient's Birthday
Patient's Height:	Patient's Weight:	Pediatrician:

How did you hear about us?

Is your child receiving care from any other health professional: Yes ○ No ○ If yes, please list their name and specialty:

_____

_____

Is your child currently taking any medications/ natural supplementation? If yes, please list what brand and dosage: _____

_____

HEALTH INFORAMATION

What health concerns about your child brought you in today?

When did this condition begin?

How did it start? Sudden ○ Gradual ○ Post- Injury ○ What injury? _____

_____

Has your child received care for this condition before? Yes ○ No ○ If yes, Explain: _____

_____

Is this condition: Worse ○ Improving ○ Intermittent ○ Constant ○ Unsure ○

What makes this concern better?	What makes this concern worse?

Does your child have any allergies Yes ○ No ○

If yes, please list them:

_____

Infancy (Under 1 years old):

List any vaccinations your child has received as well as any adverse reactions:

_____

_____

Circle which ever applies.

Infant Feeding. : Breast Formula Brand? _____

Quality of sleep: Good Fair Poor Number of hours of sleep per night? _____

Childhood years (1yr +)

Did the child have any childhood illnesses? Yes No If yes, Explain: _____

Does the child play any youth sports? Yes No If yes, Explain: _____

What are the top three health goals for your child?

1. _____
2. _____
3. _____

What are you looking for your child to gain from seeing a chiropractor?

Resolve current issue

Overall Wellness

Both

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HISTORY OF PREGNANCY

Did you carry full term? Yes ○ No ○
If no, how long did you carry?
_____

Complications during labor: Yes ○ No ○
If so, please explain:

_____
_____
_____
_____

Describe your experience:
Labor duration: _____
Location of delivery_____

Circle if the delivery was: C- Section Forceps Vacuum/ Suction Cup Vaginal

Fertility issues? Yes ○ No ○ If yes, please explain:
_____

Did mother smoke? Yes ○ No ○ If yes, please explain:
_____

Did mother Drink? Yes ○ No ○ If yes, please explain:
_____

Did mother exercise? Yes ○ No ○ If yes, please explain:
_____

Was mother ill? Yes ○ No ○ If yes, please explain:
_____

Any ultrasound exposure? Yes ○ No ○ If yes, please explain:
_____

Any medications used during pregnancy? Yes ○ No ○ If yes, please explain:
_____

Check any box that applies currently or in the past:

Seizures ○	Sensory/ Spectrum ○	Jaundice ○
Ear/ Sinus Infection ○	ADD/ADHD ○	Eczema ○
Asthma/Respiratory ○	Food Allergies ○	Allergies/ Congestion ○
Anxiety/ Stress/emotional Trauma ○	Seizures ○	Constipation/ Diarrhea / Bed Wetting ○
Colic/ Excessive Fussiness ○	Depression ○	Reflux/ GERD ○
Headaches/ Migraines ○	Chronic cough/Colds ○	Kidney issues ○
Lower Back Pain ○	Diabetes Mellitus Type ___ ○	Speech issues ○
Low Energy/ Fatigue ○	Vision/ hearing issues ○	Immune deficiency ○

Please give us any other health information you feel would be helpful: _____
_____
_____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician and Rodrock Chiropractic or insurance company to release any information required to process my claims. I understand that I am financially responsible for any balance.

Name of Parent or Guardian_____
Signature _____ Date_____

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