Pediatric Intake Form

Patient (Child) Information:

Child's Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Child's Date of Birth: _____ Age: _____ M / F Height: _____ Weight: _____

Child's SSN: _____ Name of Parents / Guardian: _____

Cell Phone: (_____)_____ Email: _____

Child's Pediatrician & Location: _____

How did you hear about us?: _____

Authorized Representative/ Parent / Guardian: _____

Present Complaint: _____

When did this begin: _____ Was there an accident or injury involved? Y N

Has your child had any past treatment for this complaint? Y N Describe: _____

Current Medications: _____

General Questions/ Prenatal History:

Any complications during pregnancy? Y N Explain: _____

Medications taken during pregnancy: _____Cigarettes or alcohol during pregnancy Y N

Birth Intervention: Forceps Vacuum C-Section

Complications during delivery? Y N

Explain: _____

Genetic disorders or disabilities: _____

How many times has your child been prescribed antibiotics in the past 6 months? _____

Total during lifetime: _____

Has your child received vaccinations? Y N

Feeding History:

Breast Fed: Y N How long? _____

Formula Fed: Y N How long? _____

Introduced to: Solids at: _____ Months

Cow Milk at: _____ Months

Food Allergies or Intolerances: Y N

List: _____

Childhood Diseases:

Chicken Pox: Y N Age: _____

Rubella: Y N Age: _____

Rubeola: Y N Age: _____

Mumps: Y N Age: _____

Whooping Cough: Y N Age: _____

Other: _____ Y N Age: _____

Pediatric Intake Form

Developmental History:

According to the National Safety Council, approximately 50% of children fall headfirst from a high place during their 1st year of life (a bed, changing table, down stairs, etc). Was this the case with your child? Y N

Explain: _____

Is/has your child been involved in any high impact or contact type of sports (soccer, football, gymnastics, baseball, cheerleading, martial arts, etc? Y N

Has your child ever been involved in a car accident? Y N Explain: _____

Other traumas not described above? Y N Explain: _____

Prior surgeries? Y N Explain: _____

During the following times, your child's spine is the most vulnerable to stress and should routinely be checked by a Doctor of Chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference).

At what age was your child able to:

_____ Respond to sound

_____ Respond to visual stimuli

_____ Hold head up alone

_____ Sit up alone

_____ Cross crawl

_____ Stand alone

_____ Walk alone

Review of Systems:

Please circle if your child has had any of the following:

Headaches	Postural	Learning	Acid Reflux	Tonsillitis
Asthma	Imbalances	Difficulties	Scoliosis	Sleep problems
Digestive	Torticollis	Growing Pains	Seizures	Frequent fevers
Problems	Bedwetting	Ear Infections	ADD/ADHD	Allergies
Colic		PDD/Autism	Hip Dysplasia	

How would you rate your child's diet? ___Well Balanced ___ Average ___ High sugar/processed foods

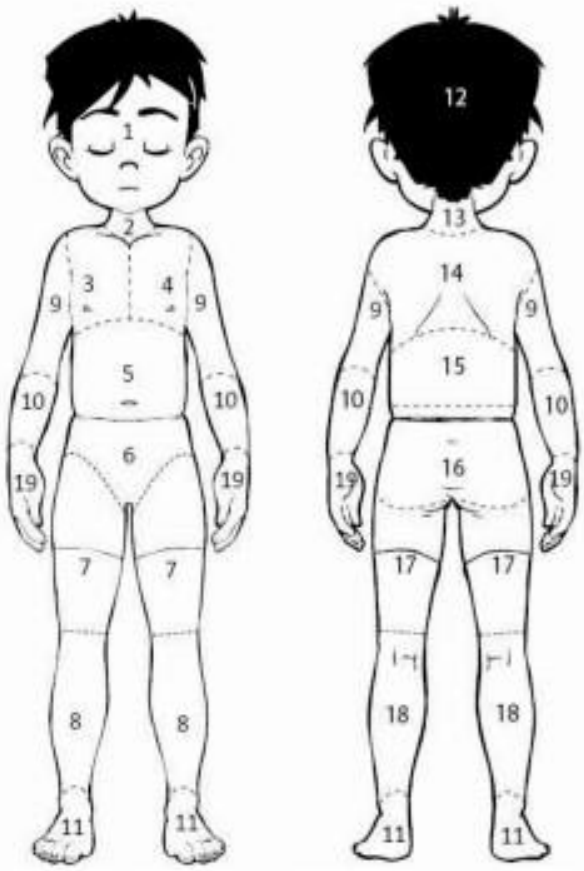
Does your child consume artificial sweeteners? Y N

Number of hours your child sleeps: _____ hours/night _____hours/day (naps)

Sleep quality: _____ Good _____ Fair _____Poor

Pediatric Intake Form

1 – face
2 – neck
3 – left chest
4 – right chest
5 – stomach
6 – abdomen
7 – thighs
8 – legs
9 – upper arms
10 – lower arms
11 – feet
12 – back of head
13 – back of neck
14 – upper back
15 – middle back
16 – lower back
17 – back thighs
18 – back legs
19 – hands



Imagine this picture is your body. Can you color the area that is hurting you right now?

Authorization to Treat a Minor

I, _____ the undersigning parent/guardian having legal custody/guardianship of _____, a minor, do hereby authorize, request and direct Dr. Nelson and whomever she might designate as assistant to perform in judgement any examination and chiropractic diagnosis or treatment which is deemed necessary.

Any specific written authorization you provide may be revoked at any time by writing to us at 4501 15th Ave South, Suite 104, Fargo, ND 58103.

Patient: _____ Signature: _____

Print name Parent/Legal Guardian