PATH

INTEGRATIVE HEALTH CENTER

Pediatric Chiropractic Intake Form

Patient (Child) Information:

Name: ______________________________ Date: ____________________

Address: ____

Sex: Male Female Date of Birth: __________ Height: __________ Weight: __________

Patient SSN: ____________________ Name of Parents/Guardian: ____________________

Home Phone: ______________ Cell Phone: ______________ Work Phone: ______________

Email: ______________________________ Would you like our newsletter emailed to you: Y N

Whom may we thank for referring you? ______________________________________

Authorized Representative/Parent/Guardian: ______________________ Phone: ______________

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

Cows 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: __________ Age: __________

Developmental History:

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

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (ie: 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 (ie: 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:______________________________

Review of Systems

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

____ Headaches	____ Postural Imbalances	____ Growing Pains	____ Scoliosis	____ Tonsillits
____ Asthma	____ Torticollis	____ Ear Infections	____ Seizures	____ Sleep Problems
____ Digestive Problems	____ Bedwetting	____ PDD/Autism	____ ADD/ADHD	____ Frequent Fever
____ Colic	____Learning Difficulties	____ Acid Reflux	____ Hip Dysplasia	____ Allergies

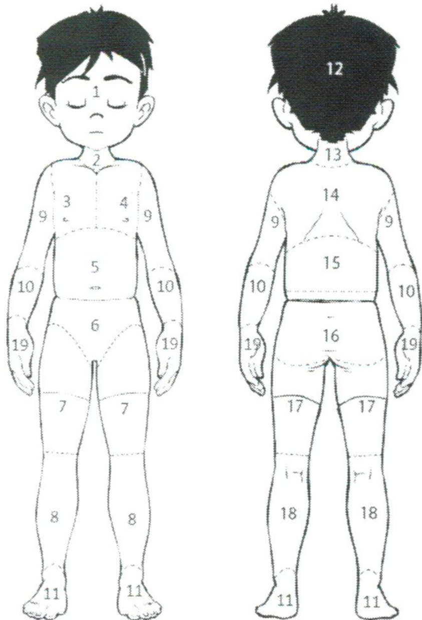
How would you rate your child's diet? ____ Well Balanced ____ Average ____High sugar/processed foods

Does your child consume artificial sweeteners? Y N

Number of hours your child sleeps:____________________ hours per night ________________hours per day/naps

Sleep Quality: ____Good ____Fair ____Poor

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



HALLAGREEN © 2010

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

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Authorization to Treat a Minor

I, ________________________________ the undersigning parent/guardian having legal custody/guardianship of ________________________________, a minor, do hereby authorize, request and direct Dr. DeCamp and whomever she might designate as assistant to perform in judgment 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 the address provided on the front of this form.

Patient: ________________________________ Signature: ________________________________

Print Name Parent/Legal Guardian