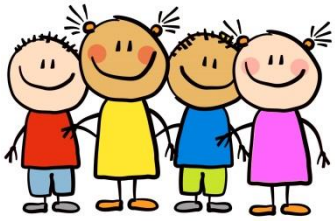
CHIROPRACTIC INTAKE & HISTORY

INFANT- 10 YEARS



Patient (Child) Information:

Name: _____ Date: _____

Address: _____

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

Patient SSN: N/A 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:

CURRENT	PREVIOUS		CURRENT	PREVIOUS		CURRENT	PREVIOUS	
☐	☐	Asthma	☐	☐	Frequent Diarrhea	☐	☐	Failure to Thrive / Slow Weight Gain
☐	☐	Respiratory Tract Infections	☐	☐	Constipation	☐	☐	Slow or Absent Reflexes
☐	☐	Sinus Problems	☐	☐	Flatulence	☐	☐	Asymmetrical Crawling or Gait
☐	☐	Ear Infections	☐	☐	Headaches/Migraines	☐	☐	Weight Challenges
☐	☐	Tonsillitis	☐	☐	Neck Pain	☐	☐	Bed Wetting
☐	☐	Strep Throat	☐	☐	Torticollis / Head Tilt	☐	☐	Sleep Problems
☐	☐	Frequent Colds / Croup	☐	☐	Trouble Feeding on One Side	☐	☐	Night Terrors
☐	☐	Recurrent Fevers	☐	☐	Back Pain	☐	☐	Tip Toe Walking
☐	☐	Eczema	☐	☐	Growing Pains	☐	☐	Sensory Processing Issues
☐	☐	Rashes	☐	☐	Scoliosis	☐	☐	Seizures
☐	☐	Allergies	☐	☐	Red, Swollen, Painful Joint	☐	☐	Tremors / Shaking
☐	☐	Food Sensitivities	☐	☐	Colic	☐	☐	ADD / ADHD
☐	☐	Digestive Problems	☐	☐	Frequent Crying Spells	☐	☐	Autism / PPD

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

Health Insurance

Insurance Company Name: _____ Insured's Name and DOB:_____

Insured's Address: _____ Relationship to Patient:_____

NOTE: Insurance companies do not cover chiropractic wellness care for children.

Acknowledgements

I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.
Signature _____

SUMMIT CHIROPRACTIC CENTER

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