Pediatric Intake Form
Ages 6-17

Patient (Child) Information:

Name: ______________________________________Called Name:_________________ Date:__________________
Address: ____
Sex: Male Female Other Date of Birth: _______________ Height:______________ Weight: _____________
Name of Parents/Guardians:____
Home Phone:_____________________ Cell Phone: ______________________ Work Phone: _____________________
Email:____
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

Food Allergies or Intolerances: Y N List:____

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 ______________ Crawl ______________ Respond to Visual Stimuli
______________ Stand Alone ______________ Hold Head Up Alone ______________ Walk Alone
______________ Sit Up Alone

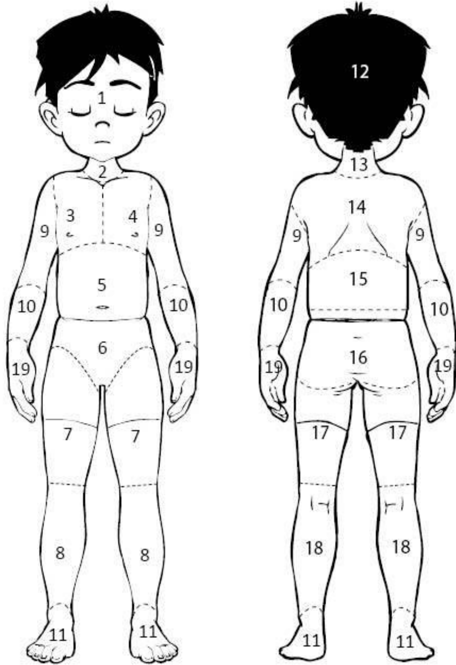
Is/has your child been involved in any high impact or contact type of sports (ie: soccer, football, gymnastics, baseball, cheerleading, martial arts, etc)? Y N
Has your child ever been involved in a car accident? Y N Explain:____
Other traumas not described above? Y N Explain:____ Prior surgeries? Y 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



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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