



CHIROPRACTIC CENTER, S.C.

Pediatric Intake Form
Ages 0-5

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:
Family History: Mother _____ Father _____
Brother _____ Sister _____

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 finish reverse side.

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

- | | | | | |
|---|--|---|--|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Postural Imbalances | <input type="checkbox"/> Growing Pains | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Torticollis | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Seizures | <input type="checkbox"/> Sleep Problems |
| <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Bedwetting | <input type="checkbox"/> PDD/Autism | <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Frequent Fever |
| <input type="checkbox"/> Colic | <input type="checkbox"/> Learning Difficulties | <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Hip Dysplasia | <input type="checkbox"/> Allergies |

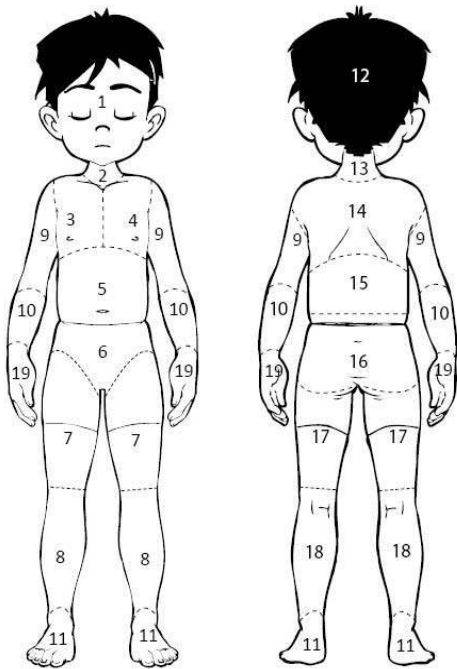
How would you rate your child's diet? Well Balanced Average High sugar/processed foods

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?



- | | | | |
|-----------------|-----------------|-------------------|------------------|
| 1 - FACE | 7 - THIGHS | 12 - BACK OF HEAD | 17 - BACK THIGHS |
| 2 - NECK | 8 - LEGS | 13 - BACK OF NECK | 18 - BACK LEGS |
| 3 - LEFT CHEST | 9 - UPPER ARMS | 14 - UPPER BACK | 19 - HANDS |
| 4 - RIGHT CHEST | 10 - LOWER ARMS | 15 - MIDDLE BACK | |
| 5 - STOMACH | 11 - FEET | 16 - LOWER BACK | |
| 6 - ABDOMEN | | | |

Authorization to Treat a Minor

I, _____ the undersigning parent/guardian having legal custody/guardianship of _____, a minor, do hereby authorize, request and direct Zelm Chiropractic Center to perform in judgment any examination and chiropractic diagnosis or treatment which is deemed necessary.

I understand & agree to the following:

There is no guarantee that my health insurance plan or policy will pay for all or part of care.

I will be informed of fees & charges before the procedure is performed.

As the guardian of the patient, I am responsible for all charges incurred from services rendered.

Patient: _____

Print Name

Signature: _____

Parent/Legal Guardian