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: ____

Genetic disorders or disabilities:____

Has your child received vaccinations? Y N

Family History: Mother_________________________ Father_________________________

Brother_________________________ Sister _________________________

Food Allergies or Intolerances: Y N List:____

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

If yes, what type?____

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	____ Tonsillitis
____ 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

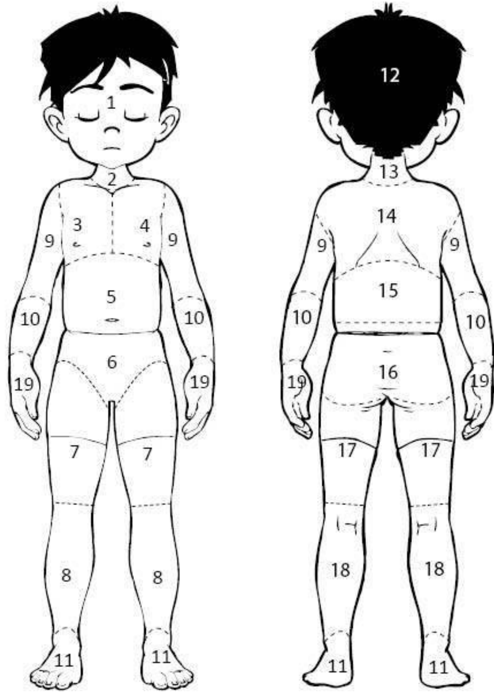
Does your child consume artificial sweeteners? Y N

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

Sleep Quality: ____Good ____Fair ____Poor

Please finish reverse side.

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



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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 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: ____ Signature: ____

Print Name Parent/Legal Guardian