Innate Chiropractic Health, LLC
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PEDIATRIC INTAKE FORM

Welcome to the office! Please read and answer the following questions completely.

Patient Name: ____

Date of Birth: ________________________ Gender: M F

Address: ____ City/State: _____________

Zip Code: ____________ Phone number: _______________________________________

Name(s) of Parent(s)/Legal Guardian(s): ____

HEALTH HISTORY

Reason for this visit: ____

Has this child had previous chiropractic care? Y/N Other Doctors seen for this condition? Y/N

Doctor's name and previous treatment: ____

Other health concerns: ____

Pertinent Family History: ____

Number of antibiotic prescriptions your child has been on in the past six months: ___________

Total number of antibiotic prescriptions your child has been on in his/her lifetime: __________

Other prescriptions your child is currently taking: ___________________________________

Number of bowel movements per day: _______________ Hours of sleep per night: _________

Has your child been vaccinated? Y/N Any reactions to the vaccines? Y/N

If your child has experienced reactions, please explain: ________________________________

PRENATAL HISTORY

Ultrasounds during pregnancy? Y/N Complications during pregnancy? Y/N

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Please describe any complications during pregnancy: ____________________________________

Medications during pregnancy or delivery? ____

Type of Delivery: Vaginal   Forceps   Vacuum Extraction   C-Section

Cigarette/Alcohol use during pregnancy? Y/N   If yes, how much? ________________________

Does your child have genetic disorders? Y/N If yes, describe: ____________________________

Does your child have developmental disorders or challenges? Y/N If yes, please describe: ____

____

Is your child breast fed? Y/N   If yes, for how long? ____________________________________

PAST HEALTH HISTORY

Automobile collisions: Y/N Describe injuries: ____

Sports/recreational activities: ____

List any injuries (falls, broken bones, concussions, etc.): _________________________________

____

Any other traumas, illnesses, diseases, conditions not listed above: ________________________

____

Hospitalizations or surgeries: ____

Please circle all that apply: Asthma   Allergies   Hyperactivity   Bed-Wetting   Ear Infections

Skin Problems   Difficulty Sleeping   Colic   Constipation/Diarrhea   Nutritional Deficiencies

Insufficient Physical Activity   Difficulty Eating/Nursing

The above information is true and accurate to my knowledge.

Parent/Guardian's Name (Print): ____

Parent/Guardian Signature: ____

Date: ____________________________________

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