PERRY FAMILY CHIROPRACTIC, LLC

PEDIATRIC INTAKE FORM

PERSONAL INFORMATION			
Name:		Date:	
Address			
City, State		ZIP code:	
Home Phone:		Cell Phone:	
Date of Birth:		Gender: ☐Male ☐Female	
Age:	Height:	Weight:	Hand: ☐Right ☐Left
Who referred you to our office? :			
Childs Primary Health Care Provider:			

EMERGENCY CONTACT INFORMATION	
Mother's name:	
Home Phone:	Cell Phone:
Father's name:	
Home Phone:	Cell Phone:
Other/Legal guardian:	Relationship:
Home Phone:	Cell Phone:

INSURANCE INFORMATION	
Co. Name:	
Address:	
Phone number:	
Insured's ID number:	
Group number (Plan, Local, or Policy #):	
Insured's Name:	
Relation:	Date of Birth:
Insured's Employer:	

PRIMARY CONCERN

Please select any of the applicable reasons for you pursuing chiropractic care for your child:

☐ He/She is continuing care from another chiropractor.
☐ I recently had my spine checked and see the value in a subluxation check-up
☐ I am concerned about his/her health and am looking for answers.
☐ He/She has a specific condition that concerns me.

- Please explain:_____

☐ Other:

Date of onset/duration:

Is this visit the result of an auto injury? ☐ Yes ☐ No

- If yes when did the accident occur:

Has your child seen another doctor for this concern? ☐ Yes ☐No

- Doctors name:

Has your child been to a chiropractor before? ☐ Yes ☐No

- Doctors name:

Has your child been treated by a physician for any condition in the previous 12 months? ☐ Yes ☐No

- If yes please explain:

MEDICATIONS (Please list medication names where possible)

☐ Antibiotics Number of doses: Past 6 months:_____, Lifetime _____	☐ Antidepressants Number of doses: Past 6 months:_____, Lifetime_____ _____	☐ Bronchodilators (Asthma) Number of doses: Past 6 months:_____, Lifetime _____
☐ Birth Control	☐ Muscle Relaxants	☐ Cold medication

☐ Anti-inflammatories / Pain killers
☐ Aspirin / ASA (acetylsalicylic acid)
☐ Advil / Ibuprofen
☐ Tylenol / Anacin / Acetaminophen
☐ Corticosteroids (prednisone, asthma drugs,etc)
☐ Robaxin / Robaxacel / Robax Platinum, etc

☐ I am currently not taking any medication

Has your child taken any medication for an extended period of time in the past? ☐ Yes ☐ No
If Yes please list:

Does your child currently take any herbal or vitamin supplementations? ☐Yes ☐ No
If yes please list:

☐ Allergies (please list):

VACCINATION HISTORY

Has your child been immunized? ☐ Yes ☐ No

Reason for vaccination: ☐ Informed decision ☐ Recommended ☐ I didn't know I had a choice

Did your child have a negative reaction to the vaccinations? ☐ Yes ☐ No
If yes were they reported? ☐ Yes ☐ No

GENERAL HEALTH HISTORY

Has there been a recent change in your child's energy level? ☐ Yes ☐ No

How would you describe your child's health? ☐ Robust ☐ Poor ☐ Good ☐ Sickly ☐ Average

At what age was your child able to :
Hold head up: Sit up: Cross Crawl: Walk alone:

Have you ever been told your child has unusual skeletal changes (e.g. Scoliosis, unusual vertebrae, short legs etc.)? ☐ Yes ☐ No
If yes please describe:

Has your child had any surgeries? ☐ Yes ☐ No

CONTINUE TO NEXT PAGE ➔

GENERAL HEALTH HISTORY CONT…

Please check the conditions your child has been treated for:

☐ Ear Infection	☐ Growing Pains	☐ Recurring Fevers
☐ Asthma	☐ Back Pains	☐ Neck Pains
☐ Colic	☐ Seizures	☐ Bed Wetting
☐ Allergies	☐ Sinus Troubles	☐ Temper Tantrums
☐ Headaches	☐ Eczema/Skin Problems	☐ Bronchitis/Upper Respiratory Infections
☐ Scoliosis	☐ Constipation / Diarrhea	☐ Attention Problems – ADD/ADHD
☐ Digestive Problems	☐ Chronic Colds	☐ Other (specify):

Family Health History

Please check the conditions that any blood relatives have had

☐ Alcoholism	☐ Cancer	☐ High Blood Pressure
☐Anemia	☐ Diabetes	☐ High Cholesterol
☐ Arteriosclerosis	☐ Emphysema	☐ Multiple sclerosis
☐ Arthritis	☐ Epilepsy	☐ Osteoporosis
☐ Asthma	☐ Glaucoma	☐ Stroke
☐ Bleed Easily	☐ Heart disease	☐ Thyroid Disease

Baby / Toddler (0-4)

Have any of the following occurred?

☐ Fall from a changing table	☐ Fall out of a crib	☐ Fall off of playground equipment
☐ Tumble down stairs	☐ Play in a Johnny Jumper	☐ Involvement in a car accident

BIRTHING HISTORY

Medications during pregnancy? ☐ Yes ☐ No

Medications during labor / delivery? ☐ Yes ☐ No

Ultrasounds during pregnancy? ☐ Yes ☐ No If yes, how many?

Were you induced? ☐ Yes ☐ No

Was you delivery: ☐ Vaginal ☐ C-section

Were any of the following used during delivery?
☐ Forceps ☐ Vacuum ☐ Extraction ☐ Other:

Was your child at the time during your pregnancy in an intra-uterine constraining position:
☐ Breech ☐ Transverse Lie (side lying) ☐ Face/Brow Presentation

Any complications during delivery? ☐ Yes ☐ No
If yes please explain:

Location of Birth:
☐ Home ☐ Hospital ☐ Birthing Center

Birth Weight: Length:

Formula Fed: ☐ Yes ☐ No, If yes how many months?

Breast Fed: ☐ Yes ☐ No, If yes how many months?

Introduced to solid foods at how many months?

Introduced to cow's milk at how many months?

CONTINUE TO NEXT PAGE ➔

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between doctor and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services deeded during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.
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Signature _____ Date ___/___/___

☐Parent ☐Guardian