Davis Family Chiropractic, PLLC

New Pediatric Intake Form

Name: ____ Sex : □ Female □ Male

Address: ________________________________ City: __________ State: _____ Zip: __________

Home Phone #: __________________ Date of Birth: ___________________

Mother's Name: __________________________ Cell/Work Phone #: ___________/___________

Father's Name: __________________________ Cell/Work Phone #: ___________/___________

Whom may we thank for referring you? ____

Name of Pediatrician? ___________________________________ Phone Number: _____________

Would you like to be on our monthly email list? □ Yes □ No Email address: ________________________

Responsible Party:

Insurance Company: ___________________________ Group #: _____________________________

Subscriber's Name: ___________________________ Date of Birth: __________________________

Relationship to Patient: ___________________ Name of Employer: ___________________________

Current Health Condition:

Purpose for Contacting Us? ____

Date of Onset?____

What caused the pain to start? Was it sudden or gradual? ______________________________________

What makes it better? ____________________ What makes it worse? _________________________

Describe the type of symptom: □Aching □Sharp □Dull □Numb □Tingling □Shooting □Burning

Has your child ever received chiropractic care before? □Yes □ No If Yes, who?_ ____________________

What treatment have you already received for your condition? □Medication □Physical Therapy □Surgery

PreNatal Health History *Check only those conditions which are applicable*

Gestational age at birth (weeks at birth): _______________ Birth Weight: ________ Birth Length: _________

Did you Experience any of the following during your pregnancy?

□ Breech position during pregnancy □ Accidents □ Smoking □ Severe stress

□ Alcohol Consumption □ Hypertension □ Toxemia □ Uncontrolled Diabetes □ Placenta previa

Type of Birth: □ Vaginal □ Planned C-Section □ Emergency C-Section

Did your child experience any of the following during labor or delivery?

□ Long or difficult labor □ Forceps/suction/Vacuum □ Fetal distress □ Low oxygen or "Blue baby"

□ Breech birth □ Rapid delivery □ Cord around neck □ Premature (2+ weeks)

Complications during delivery? □ No □ Yes What happened? ______________________________

Location of Birth: □ Hospital □ Birthing Center □ Home Birth

Breastfed? □ No □ Yes For how long? ____________ Difficulty sucking or latching on? □ Yes □ No

Formula? □ No □ Yes Which kind? ____________________

Developmental History

During the following times your child's spine is most vulnerable to stress and should be routinely checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation. At what age was child able to?

Rolling: ______ months Sitting: ______ months Crawling: __________ months Walking: ______ months

Did your child cross crawl? □ Yes □ No Army Crawl? □ Yes □ No

Has your child been involved in an auto accident? □ No □ Yes ____________________________________

Has your child ever been seen on an emergency basis? □ No □ Yes ____________________________________

Prior Surgery? □ No □ Yes ____

Check any of the following conditions your child has suffered from:

- ☐ Arm problems
- ☐ Acid reflux
- ☐ ADD/ADHD
- ☐ Anemia
- ☐ Autism spectrum disorder
- ☐ Autoimmune disease
- ☐ Back aches
- ☐ Bed wetting/enuresis
- ☐ Behavioral problems
- ☐ Brain injury
- ☐ Bronchitis
- ☐ Cerebral palsy
- ☐ Chronic ear aches
- ☐ Cold/flu
- ☐ Colic
- ☐ Bruxism(teeth grinding)
- ☐ TMJ/TMJD
- ☐ Spina bifida
- ☐ Constipation
- ☐ Diabetes
- ☐ Diarrhea
- ☐ Digestive problems
- ☐ Dizziness
- ☐ Down's syndrome (Trisomy 21)
- ☐ Dyslexia
- ☐ Growing pains
- ☐ Headaches
- ☐ Heart problems
- ☐ High blood pressure
- ☐ Joint problems
- ☐ Leg problems
- ☐ OCD (Obsessive Compulsive)
- ☐ Eczema
- ☐ Multiple sclerosis (MS)
- ☐ Hyperactivity
- ☐ Otitis media
- ☐ Muscular dystrophy (MD)
- ☐ Muscle pains
- ☐ Neck problems
- ☐ PDD/PDD-NOS
- ☐ Poor appetite
- ☐ Poor posture
- ☐ Scoliosis
- ☐ Seizures/convulsions
- ☐ Sinus trouble
- ☐ Skin problems
- ☐ Stomach aches
- ☐ Vision problems
- ☐ Erb's palsy
- ☐ Klumpke's palsy
- ☐ Brachial plexus injury
- ☐ Allergies________________
- ☐ Other __________________ __________

Has your child ever suffered the following spinal traumas?

□ Fall in Baby Walker □ Fall down Stairs □ Fall off Skateboard or Skates

□ Fall from Crib □ Fall off Swing □ Fall off Bicycle

□ Fall from Highchair □ Fall off Slide □ Fall from Bed or Couch

□ Fall off Monkey Bars □ Other ____

What other concurrent therapies are you pursuing for your child at this time:

□ Speech Therapist: __________________________ □ Physical Therapist: ______________________________

□ Occupational Therapist: ____________________ □ Special Diet: ___________________________________

AUTHORIZATION FOR CARE OF MINOR

I hereby authorize this office and its doctor(s) to administer care as they so deem necessary to my son/daughter/ward (upon approval of parent or guardian).

SIGNED: _____________________________ WITNESSED: _____________________________ DATE: ___/____/_____

I realize that I am responsible for all fees charged by this office and I agree to pay for all services provided.

SIGNED: ____ DATE: ____/______/______