

# Jaffrey Chiropractic - Pediatric New Patient Intake Form

Today's Date \_\_\_\_\_

## Pediatric History Form

It is a pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To help us serve you better, please complete the following information. We look forward to working with you to build better health for your family.

Child's Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ lbs. Name of parent(s)/guardian(s): \_\_\_\_\_ Referred by: \_\_\_\_\_

Purpose for contacting us: \_\_\_\_\_

Other doctors seen for this condition: \_\_\_\_\_

Other health problems: \_\_\_\_\_

Check any of the following conditions your child has suffered from during the past six months:

Ear infections  Asthma/Allergies  Colic  Bed Wetting  Scoliosis  Digestive Problems

Seizures  ADHD  Chronic Colds  Temper Tantrums  Headaches  Growing Pains

Recurring Fevers  Other \_\_\_\_\_

Previous Chiropractor: \_\_\_\_\_ Last Visit: \_\_\_\_/\_\_\_\_/\_\_\_\_

Reason for last visit: \_\_\_\_\_

Who is your child's pediatrician? \_\_\_\_\_ Last Visit: \_\_\_\_/\_\_\_\_/\_\_\_\_

Reason for last visit: \_\_\_\_\_

List any medications, herbs, or over-the-counter remedies that your child has taken or is currently taking: *(please include how long each of these have been used)* \_\_\_\_\_

Number of Courses of Antibiotics your child has taken in the past 6 months: \_\_\_\_\_

Number of Courses of Antibiotics taken during his/her lifetime: \_\_\_\_\_

Has your child been vaccinated?  Yes  No If No, do you plan on vaccinating your child?  Yes  No

Did you notice any problems or changes after the vaccination?  Yes  No

If yes, please explain: \_\_\_\_\_

## Prenatal History

Please list any complications during the pregnancy: \_\_\_\_\_

Did you smoke, drink, or use drugs during your pregnancy? \_\_\_\_\_

Where was your child born (hospital, home, etc.)? \_\_\_\_\_

Please check all of the interventions used during your child's birth:

Forceps  Vacuum Extraction  C-Section  Induced Labor  Epidural  Other \_\_\_\_\_

Please list any complications during delivery: \_\_\_\_\_

Birth weight: \_\_\_\_\_ Birth length: \_\_\_\_\_ APGAR score: \_\_\_\_\_

Was your child born with any genetic disorders/disabilities? \_\_\_\_\_

**Feeding History:**

Was your child breast- fed or bottle-fed (how long)? \_\_\_\_\_

When was your child introduced to solid food? \_\_\_\_\_

Are you aware of any food allergies? \_\_\_\_\_

**Developmental History:**

Would you consider your child to be developing at a "normal" rate?  Yes  No

If no, please explain: \_\_\_\_\_

According to the National Safety Council, 50% of children fall head-first. Has this happened to your knowledge?  Yes  No

Please list any sports that your child is/has been involved in (soccer, hockey, football, gymnastics, trampoline, cheerleading, diving, etc.): \_\_\_\_\_

Please list any car accidents, ER visits, surgeries, traumas, concussions, illnesses, etc. that your child has been through:

\_\_\_\_\_

Has your child had:  Chicken Pox  Measles  German Measles  Whooping Cough  Other \_\_\_\_\_

Is There Anything Else You Feel We Should Know? \_\_\_\_\_

\_\_\_\_\_

I agree that I have answered the questions on this form truthfully to the best of my knowledge.

Parent's/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_