Woodbury Family Chiropractic

PEDIATRIC INTAKE FORM

Child's First Name: _____ M.I.: _____ Last Name: _____

Preferred Name: _____ Address: _____

City / State / Zip: _____

Birth Date: _____ Age: _____ Gender: **M** **F**

Sibling(s) Names & Ages: _____

Parents' Names: _____

Best Contact Phone: _____ Cell or Home / Mom or Dad

Alternate Phone: _____ Cell or Home / Mom or Dad

Email: _____

Who can we thank for referring you or how did you hear about Woodbury Family Chiropractic?

_____

What is your reason for seeking care at Woodbury Family Chiropractic? _____

When did this begin? (if applicable) _____

Are there any major injuries and/or surgeries we should know about? _____

_____

What is this affecting that is MOST important in your child's life? (List all that apply) _____

_____

Has your child seen any other providers for this condition? (List all that apply) _____

_____

Has your child seen a chiropractor before? **Yes** **No** If yes, how long ago? _____

Clinic/Doctor Name: _____

What is your reason for the change? (if applicable) _____

Check All That Apply to Your Child:

☐ Anxiety/Depression ☐ Fatigue/Sleep Issues ☐ Constipation/Diarrhea ☐ Asthma/Chronic Bronchitis

☐ Nausea/Vomiting ☐ Colic/Acid Reflux ☐ Diabetes ☐ Back/Neck Pain/Stiffness ☐ Bed Wetting

☐ Difficulty Gaining Weight ☐ Overweight ☐ Ear or Other Infections ☐ Frequent Sickness ☐ Headaches

☐ ADD/ADHD ☐ Learning Disorders ☐ Detachment/Distant ☐ Sinus Troubles/Allergies ☐ Autism/Asperger's

☐ Irritability/Nervous ☐ Other: _____

Explain any boxes checked above (optional): _____

Is there anything else regarding your child's current condition you feel the doctor should know? _____

_____

Please list any medications your child takes: _____

VITAMINS / SUPPLEMENTS:

☐ Multi-Vitamin ☐ Fish Oil/Omega-3 ☐ Vitamin D-3 ☐ Probiotics ☐ Other: _____

PRENATAL / PEDIATRIC HISTORY

Any complications experienced during delivery (check all that apply):

- ☐ C-section delivery
- ☐ Doctor pulled or twisted baby
- ☐ Anesthesia
- ☐ Labor was induced

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- ☐ Forceps/vacuum extraction
- ☐ Premature delivery
- ☐ Other: _____
- ☐ Special medical procedures/tests
- ☐ Pushed for less than 20 minutes
- ☐ Pushed for more than 2 hours

During pregnancy, did you use any drugs, tobacco, alcohol, and/or prescription medications? **Yes** **No** If yes, please list: _____

Did you experience any illness while pregnant? **Yes** **No** If yes, explain: _____

Birth weight: _____ APGAR scores (if remembered): _____

Did you breastfeed the baby? **Yes** **No** If yes, how long? _____

Did you formula-feed the baby? **Yes** **No** If yes, how long? _____

At what age did you introduce: Solids? _____ Cow's milk? _____

Does your child exercise daily? **Yes** **No** **N/A** If yes, how much? _____

Does your child watch *more* than an hour of TV per day? **Yes** **No** If yes, how much? _____

Does your child play video games? **Yes** **No** If yes, how much? _____

Does your child eat balanced meals? **Yes** **No** If no, please explain: _____

Does your child drink soda? **Yes** **No** If yes, how much/often? _____

Does your child experience prolonged sadness? **Yes** **No** If yes, please explain: _____

Does your child have difficulty sleeping? **Yes** **No** If yes, please explain: _____

The National Safety Council reports approximately 50% of children fall head first from a high place during their first year of life (bed, changing table, stairs, etc.) Was this the case for your child? **Yes** **No** If yes, please explain:

_____

Has your child ever been hospitalized or had surgery? **Yes** **No** If yes, explain: _____

Does your child have difficulty interacting with others? **Yes** **No** If yes, explain: _____

Have you noticed that your child is nervous, twitches, shakes, or exhibits rocking behavior? **Yes** **No** If yes, explain:

_____

Has your child been involved in any high impact/contact sports (soccer, football, martial arts, cheerleading, etc.)? **Yes** **No**
If yes, please list: _____

Are you aware of any food allergies or intolerance? **Yes** **No** If yes, explain: _____

Has your child received all recommended vaccinations? **Yes** **No** If no, please explain: _____

Please rate stress levels on a scale of 1-10 (10 being highest):

School: 1 ◆ 2 ◆ 3 ◆ 4 ◆ 5 ◆ 6 ◆ 7 ◆ 8 ◆ 9 ◆ 10 Personal: 1 ◆ 2 ◆ 3 ◆ 4 ◆ 5 ◆ 6 ◆ 7 ◆ 8 ◆ 9 ◆ 10