PEDIATRIC PATIENT INTAKE

Health & Human Performance

20300 Ventura Blvd. Suite 245 Woodland Hills, CA 91364

Demographics

Patient Name:_____ Date of Birth:_____/_____/_____

Age:_____ Gender:_____ Social Security Number:_____

Address:_____ City:_____

State:_____ Zip:_____

Legal Guardian Name:_____Guardian Relation:_____

Additional Guardian Name:_____ Guardian Relation:_____

Primary Phone:_____ Type of phone: Home Work Mobile

Secondary Phone:_____ __Type of phone: Home Work Mobile

How did you hear about us? Referred by_____ Yelp Facebook Other_____

Emergency Contact Name:_____ Number:_____ Relation:_____

Chiropractic Experience

Has the patient ever been to a chiropractor? Yes No (*If No, skip to the next section*)

Date of Care: _____to_____ Reason for Care: Injury/Pain Relief Wellness/Lifestyle

What were the results? _____

History of Condition(s) and/or Concern(s)

Pediatric chiropractic care focuses on a child's ability to be healthy. The goal of care is to first address the issue that brought the child into the office for care, then to offer the child the opportunity of improved health potential and ultimately wellness.

Please identify the condition(s)/concern(s) that brought you to the office in order of importance:

First:_____

When did the condition/concern begin?_____

Second:_____ _____

When did the condition/concern begin?_____

How often are you aware of the condition(s)/concern(s) listed above?:

Constant (75-100%) Frequent (50-75%) Occasional (25-50%) Intermittent (0-25%)

The condition(s)/concern(s) has been: Getting Better Getting Worse Staying the Same

What improves the condition(s)/concern(s)?:_____

What aggravates the condition(s)/concern(s)?:_____

The condition interferes with:

___Nothing ___Sleep ___Walking/Crawling ___Sitting ___Social/Play ___School ___Other

List any other doctor or chiropractor that the patient has seen for the condition(s)/concern(s):

_____

Has the child ever had similar condition(s)/concern(s)? Yes No

Has the child stopped doing any activities since the onset of the condition(s)/concern(s)? Yes No

Please list (if applicable):_____

General Health & Lifestyle

PREGNANCY

Were there any complications to the pregnancy?: Yes No

If yes, please provide details:_____

Was the birth mother on any prescription or over-the-counter medications during pregnancy?: Yes No

If yes, please provide details:_____

Was the mother under excessive stress or illness during the pregnancy? Yes No

If yes, please provide details:_____

Did anyone in the home smoke during the pregnancy?: Yes No If so, who?_____

Was the baby ever in a breech position?: Yes No

BIRTH & DELIVERY

Where was the baby born?: Home Hospital Birthing Center Other

Delivery style: Vaginal C-section VBAC

If C-section, please explain reason:_____

How long was labor?:_____ How long was delivery?:_____

Was the labor induced with oxytocin/pitocin?: Yes No

Was an epidural administered?: Yes No

Did the newborn have a normal Apgar score?: Yes No I don't remember/I don't know

INFANCY

Has the child been vaccinated according to the California vaccination standards?: Yes No

If no, please describe vaccination history:_____

Was the child breastfed?: Yes No If yes, until what age?_____

Please list any prolonged use of medications as an infant:

Past:_____

Current:_____

Please list any surgeries that the child has had:_____

Did the child suffer from any childhood illnesses?: Yes No List applicable:_____

Did the child follow the typical landmarks progressing from crawling to walking at the appropriate ages?

Yes No If no, please explain:_____

CHILDHOOD - ***Skip this section if the child is less than 2 years of age:***

Does the child play youth sports?: Yes No List applicable:_____

Has the child fallen from a height of over 3 feet?: Yes No

If applicable, describe the fall:_____

Has the child been involved in any car accidents?: Yes No If yes, when?:_____

Has the child suffered any stressful/emotional traumas?: Yes No

If applicable, please describe the stressor:_____

Does the child enjoy school/daycare/structured environments, etc.?: Yes No Sometimes

Does the child enjoy reading?: Yes No Too young, but enjoys being read to

What are the child's two favorite foods?:_____

Does the child have any food allergies or sensitivities?:_____

Has the child even suffered from head trauma or concussion?:_____

Family History

Please **circle** any of the following conditions that a **FAMILY member** has experienced:

Diabetes	Stroke	Cancer
Arthritis	Obesity	Anxiety
Depression	Blood Pressure Issues	High Cholesterol

Please provide any additional information here that you believe would be helpful for the child's care:

_____

_____

Legal Guardian Name:_____ Relationship:_____

Signature:_____ Date:_____

FOR OFFICE USE ONLY - AGES 3 AND ABOVE:

Height:_____inches Weight:_____pounds