AGEE CHIROPRACTIC
& WELLNESS CENTER

Pediatric Chiropractic Intake Form

Thank you for allowing us the opportunity to take care of your child. Please complete the following so we can better serve your child. It is our pleasure to welcome you to our chiropractic family.

Child's Name: _____ **DOB:** _____ **SSN:** _____

Sex: _____ **Height:** _____ **Weight:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Father's Name: _____ **Mother's Name**: _____

Father's Cell Phone: _____ **Mother's Cell Phone**: _____

Home Phone: _____ **Email Address**: _____

Whom may we thank for referring you to our office? _____

In the event we need to contact you, what is the best method of communication for your family?
☐ Phone ☐ Email ☐ Text

At our office we are interested in your entire family's health and well-being. Please mention below any health conditions or concerns you may have about yourself or the other members of your family.

Yourself/Spouse: _____

Other Children: _____

Others: _____

Reason(s) for seeking care: ☐ Spinal check-up ☐ Wellness ☐ Other

Please explain: _____

Other Drs seen for this condition? Y / N

If yes, Dr's name & prior treatment: _____

_____

Previous chiropractor: _____ Date of last visit: _____

Reason: _____

Name of Pediatrician: _____ Date of last visit _____

Reason: _____

Other Health Problems

Please check any current or past problems your child has had:

☐ Dizziness	☐ Diabetes	☐ Anemia	☐ Broken Bones
☐ ADHD	☐ Tuberculosis	☐ Rheumatic Fever	☐ Sprains/Strains
☐ Autism	☐ Hypertension	☐ Poor Appetite	☐ Fainting
☐ Backaches	☐ Arthritis	☐ Hyperactivity	☐ Hernias
☐ Neck Pain	☐ Heart Condition	☐ Behavioral	☐ Arm/Elbow Pain
☐ Headaches	☐ Rash/Hives	☐ Poor Memory	☐ Leg/Hip Pain
☐ Allergies	☐ Digestive	☐ Insomnia	☐ Knee/Foot Pain
☐ Asthma	☐ Sinus Trouble	☐ Nightmares	☐ Growing Pains
☐ Runny Nose	☐ Neuritis	☐ Bed Wetting	☐ Joint Pain
☐ Itchy Eyes	☐ Cough/Wheeze	☐ Pain Urinating	☐ Scoliosis
☐ Ear Infections	☐ Chest Pain	☐ Convulsions	☐ Blood Disorders
☐ Frequent Colds	☐ Constipation	☐ Paralysis	☐ Stomach Aches
☐ Fever/Chills	☐ Diarrhea	☐ Muscle Pain	☐ Other

Please list any medications your child is taking and conditions being treated: _____
_____

Please list any vitamins/supplements/herbs/homeopathic/other your child is taking: _____
_____

Number of rounds of antibiotics your child has taken: _____

Has your child been injured in any type of accident (ie sports, car accident, major fall, etc)? Y / N

If yes, please describe: _____

Vaccination History:

☐ Up to date

☐ Chose to decline vaccinations

☐ Chose a delayed schedule

☐ Still deciding

Please describe any adverse reactions to vaccinations: _____
_____

Prenatal History:

- Name of Obstetrician/Midwife: _____
- Location of birth:
  - ☐ Hospital: _____
  - ☐ Home
  - ☐ Birth Center: _____
- Complications during pregnancy? Y / N
  Describe: _____
- Medications during pregnancy? Y / N
  Describe: _____
- Cigarette/Alcohol during pregnancy? Y / N
  If yes, please list: _____
- Ultrasound during pregnancy? Y / N
- Chiropractic care during pregnancy? Y / N
- Medications used during birth:
  - ☐ None
  - ☐ Pitocin
  - ☐ Epidural
- Interventions used during birth:
  - ☐ Breaking of water
  - ☐ Vacuum
  - ☐ Forceps
  - ☐ Episiotomy
- Complications during birth? Y / N
  If yes, please describe: _____
- Position of baby at birth
  - ☐ Head down
  - ☐ Posterior/Sunny side up
  - ☐ Breech
  - ☐ Malposition
- How long was your labor? _____
- Cesarean section? Y / N
  If yes, was it: ☐ Planned ☐ Emergency
- Genetic Disorder/Disability? Y / N
  If yes, please describe: _____
- Birth Weight: _____
- Birth Length: _____
- APGAR scores: _____
- Number of weeks of gestation at birth: _____

Feeding History:

- Breastfed: Y / N How long? _____
- Formula fed: Y / N How long? _____ Which formula? _____
- Does baby prefer feeding on one side more than the other? Y / N
- Introduced to solids at ___ months.
- Introduced to cow's milk at ___ months.
- Food/juice allergies, sensitivities, or intolerances? Y / N
  If yes, please list: _____

Developmental History

- Number of hours of sleep per night: _____
- Quality of sleep: ☐ Good ☐ Fair ☐ Poor
- During the following times, your child's spine is most vulnerable to stress and should be routinely check by a Doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference). At what age was your child able to:
    - ☐ Respond to sounds
    - ☐ Hold head up
    - ☐ Sit up
    - ☐ Crawl
    - ☐ Stand alone
    - ☐ Walk alone

Childhood Diseases

- At what age (if ever) did your child suffer from the following:
    - ☐ Chicken pox
    - ☐ Rubella
    - ☐ Measles
    - ☐ Mumps
    - ☐ Whooping cough
    - ☐ Other

WE ARE HERE TO SERVE YOU AND YOUR FAMILY AND HIGHLY ENCOURAGE YOU TO ASK QUESTIONS. YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR CHILD'S RESULTS.

AUTHORIZATION FOR CARE OF MINOR

I hereby authorize this office and its doctors to administer care to my son/daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office. I understand that my child is being treated for spinal misalignments.

Parent or Guardian Signature: _____ **Signature Date**: _____

Parent or Guardian Print Name: _____