CHILD CHIROPRACTIC INTAKE

Must be filled out by parent/guardian for children under 15 years old

Office Use Only
Reviewed: ____________________

Name: ____________________ Date of Birth: ____________________

Parent's Name: ____________________

Medical Doctor: ____________________ Last Visit to MD: ____________________

PREGNANCY

Did you carry to full term (40 weeks)? ☐ Yes ☐ No, __________ weeks

Did you consume alcohol? ☐ Yes ☐ No Did you smoke? ☐ Yes ☐ No

Did you take any medications? ☐ No ☐ Yes, list: ____________________

Describe any complications and when they occurred: ____________________

DELIVERY

☐ Vaginal Birth ☐ Caesarean Section ☐ Medical Doctor ☐ Midwife ☐ Obstetrician
☐ Hospital Birth ☐ Home Birth

Other Information: ☐ Induction ☐ Epidural ☐ Forceps ☐ Vacuum Extraction

Was there: ☐ Respiratory Delay ☐ Purple markings on face ☐ Mis-shaped skull ☐ Jaundice

Describe any complications during delivery: ____________________

CHILDHOOD

Breastfed: ☐ No ☐ Yes, how Long? ______________ ☐ Bottle Fed ☐ Formula

Number of hours your child sleeps per night? ________ hrs Quality of Sleep: ☐ Good ☐ Fair ☐ Poor

Current medications/supplements: ____________________

Previous medications/supplements, for what conditions: ____________________

Emergency/hospital visits: ____________________

Medical Conditions: ____

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Has any of the following occurred?

☐ Fall from change table/crib
☐ Tumble down stairs
☐ Involved in a car accident
☐ Play in "Jolly Jumper"
☐ Fall off playground equipment
☐ Bed wetting
☐ Frequent fevers
☐ Frequent bouts of diarrhea
☐ Did not gain weight
☐ Sleeping problems
☐ Frequent ear infections
☐ Constipation
☐ Reaction to vaccination
☐ Colic
☐ Frequent colds

REASON FOR VISIT

☐Correct and/or prevent an existing problem   ☐ Health and spinal check-up
Please fill out the information below

Symptoms and/or main problem: ____

How and when problem started: ____

The pain is: ☐ Constant ☐ Intermittent (Comes and Goes)

Please check the words that describe your pain/symptoms:
☐ Sharp ☐ Aching ☐ Throbbing ☐ Shooting ☐ Nagging

Aggravating factors: ____

Relieving factors: ____

Please describe any treatments and/or tests done for this problem, and the results: ______________________

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