RĀDIX
— CHIROPRACTIC —

# PEDIATRIC INTAKE FORM

***(Newborn to age 10)***

## PERSONAL INFORMATION

**Today's Date**_____

**Name**: (*First MI Last*) _____ **Preferred Name**:_____

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

**Gender**: ❑M ❑F **Date of Birth**:_____ **Age**:____yr/mo

**Name of Father:**_____ **Name of Mother:** _____

**Home Phone Number:** _____ **Home Phone Number:** _____

**Cell Phone Number:** _____ **Cell Phone Number:** _____

**Work Phone Number:** _____ **Work Phone Number:** _____

**Text Reminders** ❑Y ❑N **Before Visit:** ❑ 1 Hr ❑ 4 Hrs ❑ 1 Day **Cell Provider:**_____

**Legal Guardian (if other than parent):**_____ **Phone Number:**_____

**Have you received chiropractic care before**: ❑Y ❑N **When:** _____**Where:**_____

**Referred By**: (*Name*)_____ Family / Friend / Co-Worker / Internet / Other

## EMERGENCY CONTACT

**Name**: (*First MI Last*) _____ **Contact #**: _____ **Relationship**: _____

**Primary Care Physician**: _____ **Contact #:**_____

## FINANCIAL INFORMATION / RESPONSIBLE PARTY

❑Insurance ❑Time-of-Service (*Cash*) ❑Personal Injury/Auto ❑Worker's Comp ❑Other_____

**Primary Insurance Name**: _____ **Relationship to Insured**: Self / Spouse / Parent / Child

*If Other than Self:* **Insured Name**: _____ **Date of Birth**: (MM/DD/YYYY) _____

## REASON FOR SEEKING CARE

**Reason why your child is here:** ❑Wellness Check ❑Specific Condition_____

**Is this condition due to an accident or specific even/incident?** ❑No ❑Yes (*describe*)_____

**Doctor's visit or hospitalization for the current condition?** ❑No ❑Yes (*treatment rendered*)_____

**What other treatment option have you attempted to improve the current condition?**_____

**Duration of current condition:** ❑0-1 weeks ❑2-7 weeks ❑2-4 months ❑_____months/years

**Frequency of condition?** ❑Daily: number/day___ ❑Weekly: number/week___ ❑Monthly: number/month___

**Has your child ever had similar conditions in the past?** ❑No Yes: when_____

**This condition is:** ❑Getting Worse ❑Staying the Same ❑Slowly Improving ❑Rapidly Improving

**Do any of the following activities or movements aggravate the condition?** (*check all that apply)*

❑Standing ❑Sitting ❑Lying Down ❑Bending ❑Twisting ❑Walking ❑Running ❑Other_____

*Doctor's Comments:*

**PARENT/GUARDIAN SIGNATURE**_____ **DATE:**_____ **DOCTORS INITIALS**_____

## HEALTH CONCERNS

- ☐ Anxiety/Depression
- ☐ Constipation/Diarrhea
- ☐ Nausea/Vomiting
- ☐ Diabetes
- ☐ Bed Wetting
- ☐ Overweight
- ☐ Other_____

- ☐ ADD/ADHD
- ☐ Detachment/Distant
- ☐ Irritability/Nervous
- ☐ Developmental Delay
- ☐ Fatigue/Sleep Issues
- ☐ Asthma/Chronic
- ☐ Bronchitis

- ☐ Back./Neck Pain/Stiffness
- ☐ Difficulty Gaining weight
- ☐ Ear of Other Infections
- ☐ Headaches
- ☐ Learning Disorders
- ☐ Sinus Troubles/Allergies
- ☐ Autism/Asperger's/Sensory

## CURRENT HEALTH

**Current Weight:**_____ **Current Height/Length**_____

**Medications and Supplements** (including Rx and OTC)**:** ❑Yes. List below ❑None

| Supp/Med Name | Dosage | Frequency | Method |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

## PRENATAL HISTORY

**Delivery Method** (*check all that apply*): ❑Vaginal ❑Forceps ❑Vacuum Extractions ❑Caesarean Section
**Medication during pregnancy (mother) or delivery**: ❑Yes ❑No
**What position was the child during delivery** ❑normal ❑breech ❑shoulder ❑other_____
**Was the mother under chiropractic care during pregnancy?**: ❑Yes ❑No
**Any complications during the pregnancy or delivery?**: ❑No ❑Yes (*describe*)_____
**Any known congenital anomalies / defects: ?**: ❑No ❑Yes (*describe*)_____

## PAST HEALTH HISTORY

**Family Doctor Name / Pediatrician**
Dr.'s Name_____ Clinic Name/Location_____Date of Last Visit_____
**Has your child ever been in an auto accident?** ❑N ❑Y (*provide info below*)
Approximate Date: _____ Describe Accident: _____
**Has your child had any other major injuries, falls, or accidents?** ❑N ❑Y (*provide info below*)
Approximate Date: _____ Describe Incident: _____
Approximate Date: _____ Describe Incident: _____
Approximate Date: _____ Describe Incident: _____
**Has your child had any broken bones or dislocations?** ❑N ❑Y: where_____
**Is your child involved or ever been involved in any high impact or contact sports (wrestling, football, soccer, gymnastics, baseball, martial arts, etc.)?** ❑N ❑Y: types_____
**Has your child had any surgical operations or been hospitalized** ❑N ❑Y (*provide info below*)
Approximate Date: _____ Describe: _____
Approximate Date: _____ Describe: _____

## FAMILY HISTORY

**Please indicate if any of the following conditions are known in your family:** (*check all that apply; if applicable, list relationship to the child next to the condition, i.e. brother, father, etc*)

❑Cancer_____ ❑Heart Disease_____ ❑Diabetes_____
❑Headaches_____ ❑Headaches_____ ❑Other:_____;_____

**PARENT/GUARDIAN SIGNATURE**_____ **DATE:**_____ **DOCTORS INITIALS**_____

## REVIEW OF SYSTEMS

**Check "P" for Past, "C" for Current – if past and current, check both boxes.**
**If it does not apply, please check *None in this Category*.**

**General: *(constitutional)***
❑P ❑C Recent Weight Change
❑P ❑C Fever
❑P ❑C Fatigue
❑P ❑C *None in this Category*

**Musculoskeletal**
❑P ❑C Low Back Pain
❑P ❑C Mid Back Pain
❑P ❑C Neck Pain
❑P ❑C Arm Problems_____
❑P ❑C Leg Problems_____
❑P ❑C Painful Joins
❑P ❑C Stiff/Swollen Joints
❑P ❑C Sore/Weak Muscle/Joints
❑P ❑C Muscle Spasms/Cramps
❑P ❑C Broken Bones_____
❑P ❑C Other:_____
❑P ❑C *None in this Category*

**Neurological**
❑P ❑C Numbness/Tingling
❑P ❑C Loss of Feeling
❑P ❑C Dizziness/light headed
❑P ❑C Frequent/Recurrent Headaches
❑P ❑C Convulsions/seizures
❑P ❑C Tremors
❑P ❑C Stroke
❑P ❑C Other:_____
❑P ❑C *None in this Category*

**Mind/Stress**
❑P ❑C Nervousness/Anxiety
❑P ❑C Depression
❑P ❑C Sleep Problems
❑P ❑C Memory loss/Confusion
❑P ❑C Other:_____
❑P ❑C *None in this Category*

**Genitourinary**
❑P ❑C Difficulty Urinating
❑P ❑C Recurring Infection
❑P ❑C Bed Wetting
❑P ❑C Other:_____
❑P ❑C *None in this Category*

**Gastrointestinal**
❑P ❑C Loss of Appetite
❑P ❑C Blood in stool
❑P ❑C Change in bowel movements
❑P ❑C Nausea or Vomiting
❑P ❑C Abdominal pain
❑P ❑C Frequent diarrhea
❑P ❑C Constipation
❑P ❑C Other:_____
❑P ❑C *None in this Category*

**Cardiovascular & Heart**
❑P ❑C Chest Pains
❑P ❑C Rapid or heartbeat changes
❑P ❑C Blood Pressure Problems
❑P ❑C Swelling of hands, ankles, or feet
❑P ❑C Heart problems
❑P ❑C Other:_____
❑P ❑C *None in this Category*

**Respiratory**
❑P ❑C Difficulty breathing
❑P ❑C Persistent Cough
❑P ❑C Coughing blood
❑P ❑C Asthma or Wheezing
❑P ❑C Lung problems
❑P ❑C Other:_____
❑P ❑C *None in this Category*

**Eyes & Vision**
❑P ❑C Wear contacts/glasses
❑P ❑C Blurred/Double vision
❑P ❑C Glaucoma
❑P ❑C Eye disease or injury
❑P ❑C Other:_____
❑P ❑C *None in this Category*

**Ears, Nose, & Throat**
❑P ❑C Bleeding gums
❑P ❑C Bad breath or bad taste
❑P ❑C Dental problems
❑P ❑C Swollen throat or voice change
❑P ❑C Swollen glands in neck
❑P ❑C Ringing in ears
❑P ❑C Ear – ache or drainage

* *Continued on top of next column*

❑P ❑C Sinus/Allergy problems
❑P ❑C Nose Bleeds
❑P ❑C Hearing problems
❑P ❑C Other:_____
❑P ❑C *None in this Category*

**Endocrine, Hematologic, & Lymphatic**
❑P ❑C Thyroid problems
❑P ❑C Diabetes
❑P ❑C Excessive thirst or Urination
❑P ❑C Cold extremities
❑P ❑C Heat or Cold intolerance
❑P ❑C Dry skin
❑P ❑C Glandular or hormone problem
❑P ❑C Swollen glands
❑P ❑C Anemia
❑P ❑C Easily bruise/bleed
❑P ❑C Immune system disorder
❑P ❑C Other:_____
❑P ❑C *None in this Category*

**Serious Illnesses/Diseases**
❑P ❑C Chicken Pox: Age_____
❑P ❑C Measles: Age_____
❑P ❑C Mumps: Age_____
❑P ❑C Rubella: Age_____
❑P ❑C Whooping Cough: Age_____
❑P ❑C Rubeola: Age____
❑P ❑C HIV/ADIS: Age_____
❑P ❑C Cancer: Age_____
❑P ❑C Other:_____
❑P ❑C *None in this Category*

**Females Only:**
❑P ❑C Painful or Irregular periods
❑P ❑C Vaginal Discharge
❑P ❑C Other:_____
❑P ❑C *None in this Category*

*I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office to provide my child with chiropractic care in accordance with this state's statues.*

**PARENT/GUARDIAN SIGNATURE**_____**DATE**_____

**Doctor Signature**_____**Date**_____ **Initials**_____