Awaken Life Family Chiropractic, LLC

Pediatric Health Intake Form

It is a pleasure to welcome you to our family of health and healthy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To help us serve you better, please complete the following information. We look forward to working with you to build better health for your family.

Patient Name ______________________________ Birth Date _____/_____/_____

Male/Female (circle) Age _______ Address (street) ______________________________

City ______________________________ State _________ Zip _________________

Best phone #______________________ Cell/Work/Home (circle) Referred by ____________________

Email ____

Parents (Guardians) and Occupation ____ ____

____

Siblings? (names, ages) ____

Purpose for contacting us? ____

How did it start? ____

Location ______________________________ Description: ___________________________

Since the problem started, is it? ◻ About the same ◻ Getting better ◻ Getting worse

What makes it worse? ______________________ better ? ______________________________

Things you've tried at home? ____

Other doctors seen for this condition? Yes/No Doctors' names and prior treatments: __________________

____

Check any of the following conditions your child has suffered from during the past six months:

◻ Ear Infections	◻ Scoliosis	◻ Seizures	◻ Chronic colds	◻ Headaches
◻ Asthma/Allergies	◻ Digestive issues	◻ ADHD	◻ Reoccurring fevers	◻ Growing/Back pains
◻ Colic	◻ Bed wetting	◻ Car accident	◻ Temper tantrums	◻ Other _____________

Family History ____

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e. a bed, changing table, down stairs, etc.) Was this the case with your child? Yes / No

Is/has your child been involved in any high impact or contact type sports (i.e. soccer, football, hockey, martial arts, baseball, gymnastics, etc.) Yes / No; List ____

Has your child ever been involved in a car accident? Yes / No; List ______________________________

Has your child been seen on an emergency basis? Yes / No; List ______________________________

Prior surgery? Yes / No; List ____

Other traumas not described above? Yes / No; List ______________________________

List any **vitamins**, **medications** or **supplements** your child is taking ______________________________

____

Prenatal History

Name of OB/Midwife ____________________

Complications during pregnancy? Yes / No; List ____________________

Medications during pregnancy? Yes / No; List ____________________

Location of Birth? Hospital / Birthing Center / Home Was labor spontaneous or induced? (circle one)

Birth Intervention? Forceps / Vacuum Extraction / Caesarian Section: Emergency or Planned?

Medications during labor? Yes / No; List ____________________

Complications during delivery? Yes / No; List ____________________

Birth weight ____________ Birth length ____________ APGAR score ____________

Feeding History

Breast fed? Yes / No; How long? ____________

Formula fed? Yes / No; How long? ____________

Introduced to solids at: ________ months, cow's milk at ________ months

Food/Liquid allergies or intolerances? Yes / No; List ____________________

Antibiotics

Number of doses of antibiotics your child has taken:

During the last 6 months: ______, Total during his/her lifetime: ______

Number of doses of other prescription medications your child has taken:

During the last 6 months: ______, Total during his/her lifetime: ______, List: ____________

Childhood diseases

Has the child had any childhood illnesses?

Chicken Pox	Yes / No; Age ___	Mumps	Yes / No; Age ___
Rubella	Yes / No; Age ___	Whooping Cough	Yes / No; Age ___
Rubeola	Yes / No; Age ___	Other	Yes / No; Age ___

If Yes, please explain any complications: ____________________

Has the child received any vaccines? Yes / No

If yes, were there any of the following reaction to the vaccines?

□ Fever □ Change in Sleep □ Runny Nose □ Irritable □ Others ____________

Additional Comments: ____________________

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WE ARE HERE TO SERVE YOU AND ENCOURAGE YOU TO ASK QUESTIONS.

Authorization for care of a minor:

I hereby authorize this office and its Doctors to administer care of 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.

Signature ______________________________ Date ____________