HARMONY HEALTH CHIROPRACTIC

Pediatric Intake Paperwork

Office Use Only
Today's Date: ___/___/_____
HR#: _____

Patient Demographics

Name: _____ Date of Birth: _____/_____/_____ Age:_____ ☐ Male ☐ Female

Parent/Guardian Name(s): _____

Birth Height: _____ Birth Weight: _____ Current Height: _____ Current Weight: _____

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

Mother's Name: _____ Birthdate: _____/_____/_____

Mother's Phone: _____ Mother's Email: _____

Father's Name: _____ Birthdate: _____/_____/_____

Father's Phone: _____ Father's Email: _____

Pediatrician/Family MD: _____ City/State: _____

Last Visit Date: _____/_____/_____ Reason for visit: _____

Who is responsible for this bill? _____

☐Father's Social Security #: _____ ☐Mother's Social Security #: _____

☐Father's Driver's License #: _____ ☐Mother's Driver's License #: _____

☐Other (*please explain):* _____

How did you hear about us? _____

Child's Current Problem

Purpose of this visit: ☐Wellness Check-Up ☐Injury or Accident ☐Other _____

If your child is experiencing **pain/discomfort**, **please identify where and for how long**:

_____

_____

When did the problem first begin? Date: _____ ☐Unknown ☐Gradual ☐Sudden

Has this problem occurred before? ☐No ☐Yes If yes, when?: _____

Any bowel or bladder problems since this problem began? ☐No ☐Yes If yes, describe: _____

_____

Have you seen other doctors for this problem? ☐No ☐Yes If yes, whom?: _____

How long ago? _____ Days _____ Weeks _____ Months _____ Years

What were the results of past treatment? _____

How is this problem NOW?

☐Rapidly Improving ☐Improving Slowly ☐About the Same ☐Gradually Worsening ☐On and Off

Please list any medication(s) taken for this problem: _____

Practice Member's Name: _____ HR#:_____ Date: _____

Has your child ever sustained an injury playing organized sports? ☐No ☐Yes **If yes**, please explain:

_____

_____

Has your child ever sustained an injury in an auto accident? ☐No ☐Yes **If yes**, please explain:

_____

_____

How does this condition affect your child's daily life?

☐Holding Head Up	☐Crawling	☐ Climbing Stairs
☐Tummy Time	☐Standing	☐Getting Dressed
☐Nursing	☐Walking	☐Playing with Friends
☐Sitting Up	☐Running	☐Sleep

☐Other _____

Has Your Child Ever Suffered From - *check all that apply*

			Fall From
☐ ADD/ADHD	☐ Digestive Disorders	☐ Orthopedic Problems	☐ Baby Walker
☐ Anemia	☐ Dizziness	☐ Poor Appetite	☐ Bed/Couch/Furniture
☐ Arm/Hand Problems	☐ Ear Infections/Aches	☐ Poor Posture	☐ Bicycle
☐ Asthma	☐ Fainting	☐ Reflux	☐ Changing Table
☐ Back Aches	☐ Growing Pains	☐ Ruptures/Hernia	☐ Crib
☐ Bed Wetting	☐ Headaches	☐ Scoliosis	☐ High Chair
☐ Behavioral Problems	☐ Heart Trouble	☐ Seizures/Convulsions	☐ Monkey Bars/Playground
☐ Broken Bones	☐ Hypertension	☐ Sinus Trouble	☐ Skateboard/Skates
☐ Colds/Flu	☐ Joint Problems	☐ Sleeping Problems	☐ Slide
☐ Colic	☐ Leg/Food Problems	☐ Stomach Aches	☐ Stairs
☐ Constipation	☐ Muscle Pain	☐ Walking Trouble	☐ Swing
☐ Diarrhea	☐ Neck Problems		

☐ Allergies to: _____

☐ Other: _____

Pregnancy History

How was your pregnancy? _____

Any pregnancy complications? _____

Please list any medication(s) used during pregnancy: _____

_____

Cigarettes or alcohol during pregnancy? ☐ Yes ☐ No Did mother exercise during pregnancy? ☐ Yes ☐ No

Was mother ill during pregnancy? ☐ Yes ☐ No If yes, please explain: _____

Please explain any notable concerns or remarks about your child's conception or pregnancy:

_____

_____

Practice Member's Name: _____ HR#:_____ Date: _____

Delivery Information

Child's birth was: ☐Vaginal Delivery ☐Planned Cesarean Birth ☐Emergency Cesarean Birth

Child's birth was at: ☐Home ☐Birth Center ☐Hospital

Doctor/Obstetrician/Midwife Name(s): _____

Please check any complications or interventions:

☐Breech ☐Induction ☐Pain Meds ☐Epidural ☐Episiotomy ☐Vacuum Extraction ☐Forceps

At how many weeks was your child born? _____

Post-Birth Information

Breast Fed: ☐Yes ☐No How long? _____ Formula Fed: ☐Yes ☐No How long? _____

Introduced Solid Foods at _____ mos

Food Allergies or Intolerances: _____

Doses or antibiotics/prescription drugs you child has taken: Past 6 months _____ Total Lifetime: _____

Present prescription drugs/dosage? _____

Over the counter drugs (Tylenol, cough syrup, laxatives, etc.): _____

_____

List all surgical operations & years: _____

_____

Has your child ever been knocked unconscious? ☐Yes ☐No Fractured a bone? ☐Yes ☐No

If yes to either of the above, please describe: _____

I understand that I am directly and fully responsible to Harmony Health Chiropractic for all fees associated with chiropractic care that my child receives.

The risks associated with exposure to ionization and spinal adjustments have been explained to me to my complete satisfaction, and I have conveyed my understanding of these risks to the doctor. After careful consideration, I do hereby request and authorize imaging studies and chiropractic adjustments for the benefit of my minor child for whom I have the legal right to select and authorize health care services on behalf of.

Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other guardian is not required. If my authority to so select and authorize this care should change in any way, I will immediately notify this office.

_____ _____ - _____ - _____

Parent or Legal Guardian's Signature **Date Completed**

_____ _____ - _____ - _____

Doctor's Signature **Date Form Reviewed**