Naturally Aligned Family Chiropractic, P.A.
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: _____

_____

_____

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 _____