PEDIATRIC INTAKE FORM

Date: ________________________

Personal Information

Child's First Name: ____________________ M.I.:_________ Last Name:______________________

Preferred Name: __________________________Social Security Number:______________________

Address: ____

City / State / Zip: ____

Birth Date: ____________________ Age: _______________ Sex: M or F

# of Siblings: __________________

Sibling (s) Names & Ages: ____

____

Parents' Names:____

Best Contact Phone: ( ) __________________________________

Alternate Phone: ( ) ____________________________________

Email: ____

Who can we thank for referring you or how did you hear about Purvis Chiropractic?

____

____

Reason For Seeking Care

What is your reason for seeking care at Purvis Chiropractic? ______________________________

____

When did this begin? (If applicable) ____

Are there any major injuries and/or surgeries we should know about? _____________________

____

What is this affecting that is MOST important in your child's life? (List all that apply) ____________

____

Has your child seen any other provider for this condition? (List all that apply)___________________

____

Has your child seen a chiropractor before? Yes_____ or No ______

How long ago? __________________ Clinic/ Doctor Name: ___________________________________

What is your reason for the change? (If applicable) ____

What is your level of commitment to your child's health? 1 2 3 4 5 6 7 8 9 10

Explain: ____

What health goal, if your child were to complete or accomplish it, would have the greatest impact on his/her life? ____

____

HEALTH CONCERNS

□ Anxiety/ Depression	□ Constipation/ Diarrhea	□ Nausea/ Vomiting
□ Fatigue/ Sleep issues	□ Asthma/ Chronic Bronchitis	□ Colic/ Acid reflux
□ Back/ Neck Pain/ Stiffness	□ Difficulty Gaining Weight	□ Overweight
□ Diabetes	□ Bed Wetting	□ Ear or Other Infections
□ Frequent Sickness	□ ADD/ ADHD	□ Detachment/ Distant
□ Headaches	□ Learning Disorders	□ Sinus Troubles/ Allergies
□ Irritability/ Nerves	□ Autism/ Asperger's	□ Other
□ Other	□ Other	□ Other

Explain any boxes checked above:

____

____

____

____

Is there anything else regarding your child's current condition you feel the doctor should know?

____

____

____

____

MEDICATIONS

□ Anxiety/Depression	□ Migraine/ Headache
□ Asthma	□ Acid Reflux
□ Pain Narcotics	□ ADD/ ADHD
□ Antibiotics	□ Digestive
□ Vitamins	□ Other
□ Other	□ Other

Explain any boxes checked above:

____

____

____

____

AUTHORIZATION FOR EXAMINATION OF A MINOR

I, ______________________________, hereby authorize and consent to the chiropractic examination and treatment of my infant, child, or adolescent at Purvis Chiropractic.

Parent/Guardian Signature: ___________________________________ Date:______________________________

PRENATAL HISTORY

Location of birth: Home Birthing Center Hospital Other: ______________________
Did any of the following happen during delivery:

□ C-section Delivery	□ Doctor pulled or twisted baby	□ Forceps/ Vacuum extraction	□ Special medical procedures/ tests
□ Anesthesia	□ Premature Delivery	□ Labor was induced	□ Other

Describe any of the above plus any additional complications experienced during delivery:
____
During pregnancy, did you use any drugs, tobacco, alcohol, and/or medications? If yes, please list:
____
Did you experience any illness while pregnant? Yes__ or No __ If yes explain ________________________
Do you have any physical disabilities? Yes ___ or No ___ If yes explain____________________________
Birth Weight: _____________ Birth Length: _______________ APGAR scores (if remember):_________
Ultrasound used during pregnancy? Yes____ or No ____ Number of times: _________
Did you breastfeed the baby? Yes ____ or No ____ If yes, how long: __________
Did you formula-feed the baby? Yes ____ or No _____ If yes, how long: ___________
At what age did you introduce: Solids: ____________ Cow's Milk: ______________

LIFESTYLE HABITS

Does your child exercise daily? Yes _____ or No ______ How much? ______________________________
Does your child drink soda? Yes _____ or No ______ How much/often? ___________________________
Does your child have a positive self-esteem or self-image? Yes ____ or No _____
Does your child watch more than an hour of TV per day? Yes ___ or No ____ How much? ____________
Does your child eat balanced meals? Yes ___ or No____
Does your child experience prolonged sadness? Yes ___ or No ___ Explain: ________________________
Does your child have difficulty sleeping? Yes ____ or No ____ Explain: ___________________________
Does your child play video games? Yes____ or No ____ How much? ______________________________

CURRENT HEALTH STATUS

Has your child fallen head first from a high place (bed, changing table, stairs, etc.)? Yes ___ or No___
Explain: ____
Has your child ever been hospitalized or had surgery? Yes ___ or No___ Explain:________________
____
Does your child have difficulty interacting with others? Yes___ or No___ Explain:_______________
____
Have you noticed that your child is nervous, twitches, shakes, or exhibits rocking behavior?
Yes ___ or No ____ Explain: ____
Has your child been involved in any high impact/contact sports (soccer, football, martial arts, cheerleading, etc.)? Yes ___ or No ___ Please list:_____________________________________
Are you aware of any food allergies or intolerance? Yes___ or No___ Explain:__________________
____
Has your child received all recommended vaccinations? Yes ___ or No___ Explain: ______________
____
Please rate stress levels on a scale of 1-10 (10 being highest)

School: 1 2 3 4 5 6 7 8 9 10 Personal: 1 2 3 4 5 6 7 8 9 10