Summit Chiropractic Pediatric Intake

CLIENT INFORMATION

First Name: _____________________________________ **Last Name:** __________________________________

Parents / Guardians Name: ____

Address: ____

City/State/Zip: ____

Phone: (_____)_________________________________ **E-mail:** _______________________________________

Childs Date of Birth: _____ / _____ / _____ **Age**: ______ **Gender**: ☐ Male ☐ Female ☐ Other ______

Has your child ever been to a chiropractor before? ☐ Yes ☐ No

If so, how was your experience? ____

____

Do you have any other children? ☐ Yes ☐ No **If so how many?** ______

What are their names? ____

What would you like your child to receive from care at this office?_____________________________________

____

Who may we thank for referring you to Summit Chiropractic? _______________________________________

History of Birth & Labor

Name of Obstetrician / Midwife:

____

Members of Birth Team :

____

Name of child's MD / Pediatrician : ____

Location of Birth: ____

Any assistance required during birth? (Forceps/Vacuum extraction/Cesarean) : ________________________

Any complications during birth? ____

What was child's gestational age at birth? _________ **weeks**

Birth weight: ______________ **Birth Length:** _____________

Congenital anomalies/defects present? ____

Was your child subject to any of the following:

Incubation? ☐ Yes ☐ No If so how long? _________

Separation from mother? ☐ Yes ☐ No If so how long? _________

Childs APGAR score at birth? _________

Mothers position during labor (back, side, sitting, standing, lunge…) : ________________________________

Position of baby at birth? ☐ Cephalic (head first) ☐ Breech (feet first) ☐ Occiput Posterior (facing forward)

Was labor induced? _________________________________

Did the mother receive any drugs before, during, or after the birth process? (Epidural, morphine, other):

____

Duration of labor and delivery: ______________________

Growth & Development

At what age did your child:

- ☐ Follow an object: ____________
- ☐ Hold up head____________
- ☐ Sit unassisted____________
- ☐ Crawl____________
- ☐ Respond to sound____________
- ☐ Vocalize____________
- ☐ Teethe____________
- ☐ Walk ____________

Do you consider your child's sleeping pattern normal?

____

____

Any sensitivity to sounds, textures, touch, clothing, foods? Please explain

____

____

Does your child have difficulty learning, difficulty speaking, or difficulty with attention? Please explain.

____

____

Any health problems in the immediate family (siblings, mom, dad)?

____

____

Chemical Stressors

Any illnesses during the pregnancy? If so, did mother take any medications?

____

____

During the pregnancy did the mother… if yes to any of the below please explain how much and how often.

- ☐ **Smoke?** ____________
- ☐ **Consume alcohol?** ____________
- ☐ **Take supplements?** ____________
- ☐ **Take prescription or over the counter drugs?** ____________
- ☐ **Receive ultrasounds or other radiation?** ____________
- ☐ **Receive any invasive procedures during pregnancy (amniocentesis, etc.)** ___________

Was/Is your child breastfed? (until what age?)

____

Was formula introduced? At what age?

____

Was cows milk introduced? At what age?

____

Introduced solid foods at what age?

____

Please list your child's history of antibiotic use and types:

____

____

Is your child on the current vaccine schedule, delayed schedule , or opted out?

____

Any negative reactions to vaccinations?

____

____

Any smokers in the house?

____

Any food sensitivities?

____

Physical Stressors

Any traumas for the mother during pregnancy? (falls, car accidents, etc):

____

____

Any evidence of birth trauma to your child? (check all that apply):

- ☐ Bruising
- ☐ Odd shaped head
- ☐ Fast or excessively long birth
- ☐ Stuck in birth canal
- ☐ Respiratory depression
- ☐ Cord around neck

Any child falls from couches, beds, changing tables, etc?

____

Any child trauma resulting in bruises, fractures, or stitches?

____

Any trips to the hospital or any surgeries?

____

Any sports participation and age began? (list sports and number of hours each week)

____

Approximate hours of outdoor playtime each week?

____

Is a school backpack used?

____

Additional comments about any PHYSICAL complaints your child may have?

____

____

____

Emotional Stressors

Did the mother have any issues with lactation? If so, was a lactation consultant or other health care provided sought out?

____

____

Does your child have any night terrors, sleep walking, or difficulty sleeping?

____

Average number of hours your child sleeps?

____

Average number of hours your child is in front of a screen (computer, cell phone, iPad, etc)?

____

Do you feel your child's social and emotional development is normal for their age? (please explain)

____

Does your child deal with any behavioral issues (at home, school, etc?)

____

What are your top three health goals for your child?

____

____

____

Is there any other information you would like to share that you feel may be relevant to your care here at Summit Chiropractic?

____

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____

Thank you for your time & energy put into filling out this form. We look forward to serving you!

I have filled this form out to the best of my knowledge. I understand that I am financially responsible for the care I receive at Summit Chiropractic. I understand that full payment is due at the time of service.

_________________________________ _______________________

Patient/Guardian Print Date

____

Patient/Guardian Signature