Performance Chiropractic

PEDIATRIC PATIENT INTAKE

PATIENT INFORMATION

Today's Date / /

First Name _____ **Last Name**_____ **MI** ____ **Nickname**_____

Address_____ **City** _____ **State**_____ **Zip** _____

Sex ❑M ❑F **DOB** / / **SSN** - -

Primary Phone: ( ) _____ **Email:** _____

Race ❑Am Indian/Alaska Native ❑Asian ❑Black/African Am ❑White(Caucasian) ❑Native Hawaiian/Pacific Islander ❑I Decline to Answer

Ethnicity ❑Hispanic or Latino ❑Not Hispanic or Latino ❑I Decline to Answer **Preferred Language** _____

Referred to us by (❑Friend ❑Relative ❑Physician ❑Internet ❑Yellow Pages) _____

PARENT/GUARDIAN INFORMATION

Name _____ **DOB** / /

Occupation _____ **Employer** _____

We recognize the importance of maintaining the safety and security of your child and his/her protected health information. We also realize that you may not personally be able to accompany your child to all scheduled appointments. Please list family members or other adult representatives that might bring your child to our clinic. Please note that any patient younger than 15 years of age is expected to have an adult accompany them for all scheduled appointments.

Name _____ **Relationship to Child** _____

Name _____ **Relationship to Child** _____

PATIENT HEALTH HISTORY

Please list your child's **Medications** and the **Reason** for taking *(If none, please check box)* **❑None** ***OR*** **❑See Attached List**

1) _____ 3) _____

2) _____ 4) _____

Please list all **Medical Conditions** your child has had *(If none, please check box)* **❑None**

1) _____ 3) _____

2) _____ 4) _____

What is your child's **Vaccination** history?

❑ **Fully** Vaccinated According to Schedule ❑ **Modified** Vaccination Schedule ❑ **Not** Vaccinated

Please check all **Childhood Diseases** your child has had *(If none, please check box)* **❑None**

❑ Chicken Pox ❑ Mumps ❑ Measles ❑ Whooping Cough ❑ Other_____

Please list your child's previous **Surgeries**	Please list your child's known **Allergies**
Please list your child's previous **Hospitalizations**, including **ER** visits	Please list your child's previous **Injuries**, including **Severe Falls**
Is your child exposed to **Second-Hand Smoke** or **Vapor**, at home or other?	Does your child take any **Dietary Supplements**?

FAMILY HISTORY

Have your child's ***Grandparents***, ***Parents***, **or** ***Siblings*** had any of the following? (*check all that apply*) **❑None**

❑Cancer/Tumor ❑Heart Disease ❑Mental Illness ❑Stroke ❑Obesity ❑Diabetes ❑Autoimmune Disorder ❑Other_____

4350 South Washington Street Suite 100
Grand Forks, ND 58201
(701) 732-2888

File#_____

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PRENATAL AND BIRTH INFORMATION

Name of Obstetrician/Midwife _____ **City**_____ **State** _____

Complications during pregnancy? *(check all that apply)* ❑ None
❑ Bed Rest ❑ Preeclampsia ❑ Pain ❑ Gestational Diabetes ❑ Other_____

Ultrasounds during pregnancy? ❑ None
If yes, how many? _____ At what time? _____What reasons? _____

Medications during pregnancy, **including OTC**? ❑ None
If yes, please list the medication with dosage and frequency _____

Smoke/Use Tobacco, including **e-Cigarettes** during pregnancy? ❑ No ❑ Yes ❑ Quit during pregnancy

Exposed to Second-Hand Smoke or Vapor during pregnancy? ❑ No ❑ Yes

Drug or Alcohol use during pregnancy? ❑ No ❑ Yes

Location of birth? ❑ Hospital ❑ Birthing Center ❑ Home ❑ Other _____

Birth Interventions?
Medical Procedures: ❑ None ❑ Forceps ❑ Vacuum Extraction ❑ C-section *(❑planned OR ❑emergency)* ❑ Other _____
Medication: ❑ None ❑ Epidural ❑ Pitocin ❑ Other _____

Genetic Disorder/Disability ❑ None ❑ Heart Defect ❑ Cleft Lip/ Palate ❑ Down Syndrome ❑ Spina Bifida ❑ Other _____

Length of Labor _____ hrs. **Time spent pushing** _____ hrs. **Gestational age at birth** _____ wks.

Birth Weight_____lbs. _____oz. **Birth Length** _____in. **APGAR Scores**_____:_____

GROWTH AND DEVELOPMENT INFORMATION

How would describe your child's sleep? ❑ Poor ❑ Fair ❑ Good ❑ Excellent; Hours per night_____

Feeding History
Breastfed ❑ No ❑ Yes *If yes, how long?* _____ Supplements taken by Mother_____
Formula fed ❑ No ❑ Yes *If yes, how long?* _____ Type of formula_____
At what age introduced to: ●Solid foods? _____ ●Cow's Milk? _____ ●Almond Milk? _____ ●Rice Milk? _____ ● Coconut Milk? _____

At how many months of age was your child able to do each of the following?
Hold head up _____*months* **Sit up** _____*months* **Crawl** _____*months* **Stand** _____*months* **Walk** _____*months*

HEALTH PROBLEM

Main Problem _____ **Date problem began** _____

How did this problem begin? ❑ Suddenly ❑ Gradually ❑ Accident/Injury

How is the problem changing? ❑ Getting Worse ❑ Improving ❑ Not Changing ❑ Not Sure

Has your child had this problem in the past? ❑ Yes ❑ No *If yes, when was the last episode?* _____

Is this problem affecting your child's ability to *(check all that apply)*
❑ Play/Be Active ❑ Be Outside ❑ Sleep ❑ Behave ❑ Concentrate ❑ Other_____

What makes the problem better? _____

What makes the problem worse? _____

Have you visited anyone else for this problem? ❑ No ❑ Yes
If yes, who did you visit? _____Type of treatment _____

X Parent/Guardian Signature _____

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