SCHOOL AGED CHILD (AGES 5-17) CHIROPRACTIC INTAKE FORM

Thank you for allowing us the opportunity to take care of you and your family. Please complete the following information so we can better serve your child. It is a pleasure to welcome you to our chiropractic family.

Child's Name _____ DOB: ____/____/____ Age _____ Sex M / F
Height _____ Weight _____ # of Siblings _____ Parent Email _____
Name of Parents/ Guardians _____
Address_____ City _____ State_____ Zip _____
Mother's Cell #_____ Father's Cell # _____
Child's Cell # (If Applicable) _____
How did you hear about our office? _____

IS THERE A SPECIFIC REASON FOR BRINGING YOUR CHILD IN?
__No. I'm interested in having my child's nervous system assessed to achieve optimal health and functioning.
__Yes Reason(s) for seeking care _____
Other providers seen for this condition Yes / No If yes, provider name(s) and prior treatment:
_____

If yes, please answer the following questions:
Does your child appear to be in pain or discomfort? No/Yes Has it been the same, better or worse? (please circle)
How long has your child been experiencing this? _____ Was the onset sudden or gradual? (please circle)
Has your child taken any medication for this complaint? No/Yes _____
Has your child ever experienced this complaint before? No/Yes _____
Has your child had any x-rays or further testing for this complaint? No/Yes _____

OTHER HEALTH PROBLEMS
Please check any current or past problems your child has had on the list below:

__Delayed Milestones	__Allergies	__ADHD	__Broken Bones
__Slow/Absent Reflexes	__Asthma	__Autism	__Sprains/Strains
__Emotional Outbursts	__Sinus Infections	__Hyperactivity	__Fainting
__Anxiety	__Rashes/Hives	__Behavioral	__Hernias
__Depression	__Runny Nose	__Scoliosis	__Arm/Elbow Pain
__Tonsilitis	__Itchy Eyes	__Joint Pain	__Headaches
__Strep Throat	__Cough/Wheeze	__Growing Pains	__Neck Pain
__Reflux	__Gassiness	__Night Terrors	__Back Pain
__Food Sensitivities	__Constipation	__Bed Wetting	__Arm/Elbow Pain
__Weight Challenges	__Diarrhea	__Restless Sleep	__Leg/Hip Pain
__Chronic Ear Infections	__Poor Appetite	__Seizures	__Knee/Foot Pain
__Frequent Sickness	__Stomach Aches	__Heart Condition	__Tip Toe Walking

Other Conditions Not Listed: _____

HEALTH HISTORY

Previous Chiropractor(s): _____ Reason for Care:_____
Name of Pediatrician: _____ Date of last visit: _____
Reason for visit: _____
Number of antibiotics taken in lifetime:_____ Condition(s) treated: _____
Medications and conditions being treated: _____
Has your child been injured in any type of accident (ie. physical trauma, car accident, major fall, etc.)? Y/N
If yes, please describe with dates:_____
Prior surgeries or hospitalizations? Y/N Type and Date: _____
Vaccination History: _____

GOALS FOR CARE

Please list your top 3 goals for your child's care in our office:

1._____

2._____

3._____

WE ARE HERE TO SERVE YOU AND ENCOURAGE YOU TO ASK QUESTIONS.
YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR CHILD'S RESULTS.

AUTHORIZATION FOR CARE OF MINOR

I hereby authorize this office and its Doctor(s) to administer care to 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.

Parent or Guardian-Print Signature Date