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Pediatric Chiropractic Intake Form - Ages 6-11 Years Old

Patient (Child) Information:

Name: _____ Date: _____
Address: _____
Sex: Male Female Date of Birth: _____ Height: _____ Weight: _____
Name(s) of Parents/Guardian: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Email: _____ Would you like our newsletter emailed to you: Y N
How did you hear about our office? _____

Present Complaint: _____
When did this begin? _____ Was there an accident or injury involved? Y N Has
your child had any past treatment for this complaint? Y N Describe: _____
Current medications: _____

General Questions/Prenatal History:

Birth: Vaginal C-Section (emergency / planned)
Complications during delivery? Y N Explain: _____
Genetic disorders or disabilities: _____
How many times has your child been prescribed antibiotics in the past 6 months? _____ Total during lifetime: _____
Has your child received vaccinations? Y N If yes, is it the full or graduated schedule? _____
Is/has your child been involved in any high impact or contact type of sports (ie: soccer, football, gymnastics, baseball, cheerleading, martial arts, etc)? Y N
Has your child ever been involved in a car accident? Y N Explain: _____
Other traumas not described above? Y N Explain: _____
Prior surgeries? Y N Explain: _____

DIET: How would you rate your child's diet? Well Balanced Average High sugar/processed foods

SODA: How many cans consumed/day? _____

SCREEN TIME (TV, Gaming, iPad, etc.): How many hours/day? _____

SLEEP: Number of hours your child sleeps: _____ hours per night _____ hours per day/naps

PILLOW: How many used _____ years old _____ MATTRESS: type _____ years old _____

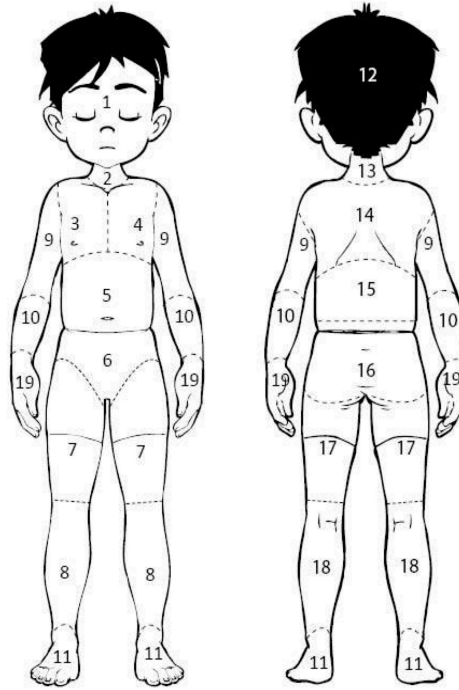
Sleep Quality: ☐ Good ☐ Fair ☐ Poor

Does your child wear a back pack? Y N Does he/she use both straps? Y N

Approximate weight of backpack _____

Past Chiropractic Care? Yes No Who? _____ When? _____

- 1 – face
- 2 – neck
- 3 – left chest
- 4 – right chest
- 5 – stomach
- 6 – abdomen
- 7 – thighs
- 8 – legs
- 9 – upper arms
- 10 – lower arms
- 11 – feet
- 12 – back of head
- 13 – back of neck
- 14 – upper back
- 15 – middle back
- 16 – lower back
- 17 – back thighs
- 18 – back legs
- 19 – hands



Imagine this picture is your body.
Can you color the area that is
hurting you right now?

Review of Systems:

Please check if your child has had any of the following:

- ☐ Headaches
- ☐ Postural Imbalances
- ☐ Growing Pains
- ☐ Scoliosis
- ☐ Sensory Processing
- ☐ Asthma
- ☐ Torticollis
- ☐ Ear Infections
- ☐ Seizures
- ☐ Tonsillitis
- ☐ Sleep Problems
- ☐ Constipation
- ☐ Bedwetting
- ☐ Autism
- ☐ ADD/ADHD
- ☐ Frequent Fever
- ☐ Colic
- ☐ Learning Difficulties
- ☐ Acid Reflux
- ☐ Hip Dysplasia
- ☐ Allergies

Informed consent:

The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures, whatever he/she is suffering from - a latent pathological defect, illnesses or deformities - which would otherwise not come to the attention of the chiropractic physician.

Authorization to Treat a Minor

I, _____ the undersigning parent/guardian having legal custody/guardianship of _____, a minor, do hereby authorize Heartland Family Chiropractic and its Doctors to perform in judgment, any examination and chiropractic treatment, which is deemed necessary.

I clearly understand and agree that I am personally responsible for payment of all fees charged by this office. Any and all x-rays remain property of the clinic as part of patient's permanent record.

ACKNOWLEDGMENT

I have reviewed the notice of privacy practices (HIPPA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

COMMUNICATION

May we leave messages on any answering device, i.e. home answering machines or voicemails? ☐ Yes ☐ N

MISSED APPOINTMENTS

There is a possible \$20 fee charged for all appointments that are not cancelled prior to scheduled visit.

Any specific written authorization you provide may be revoked at any time by writing to us at the above address.

Patient: _____

Print Name

Signature: Parent/Legal Guardian

Date

Symptom Survey

List problems from most severe to least severe. Please be as specific as possible.

Problem #1. _____

Location of pain: _____

Severity of pain: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain imaginable) Pain is? Mild Moderate Severe

Progression (circle): same better worse How often is the pain present? Constant 50-75% 25-50% less than 25%

When did you notice the problem? _____ What happened? _____

Better with (circle): rest ice heat stretching exercise pain relievers topical creams other _____

Worse with (circle): sitting standing walking bending twisting lifting movement other _____

Quality of pain (circle): sharp shooting dull ache burning stiff stabbing throbbing numb sore

Does your pain radiate (example: travel into arms, legs etc.) Yes No Where? _____

What time of day is your problem the worse (circle): morning afternoon evening during sleep

What treatment have you received for this condition: medication physical therapy surgery chiropractic
other _____ Did it help? Y N

Problem #2. _____

Location of pain: _____

Severity of pain: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain imaginable) Pain is? Mild Moderate Severe

Progression (circle): same better worse How often is the pain present? Constant 50-75% 25-50% less than 25%

When did you notice the problem? _____ What happened? _____

Better with (circle): rest ice heat stretching exercise pain relievers topical creams other _____

Worse with (circle): sitting standing walking bending twisting lifting movement other _____

Quality of pain (circle): sharp shooting dull ache burning stiff stabbing throbbing numb sore

Does your pain radiate (example: travel into arms, legs etc.) Yes No Where? _____

What time of day is your problem the worse (circle): morning afternoon evening during sleep

What treatment have you received for this condition: medication physical therapy surgery chiropractic
other _____ Did it help? Y N

Problem #3. _____

Location of pain: _____

Severity of pain: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain imaginable) Pain is? Mild Moderate Severe

Progression (circle): same better worse How often is the pain present? Constant 50-75% 25-50% less than 25%

When did you notice the problem? _____ What happened? _____

Better with (circle): rest ice heat stretching exercise pain relievers topical creams other _____

Worse with (circle): sitting standing walking bending twisting lifting movement other _____

Quality of pain (circle): sharp shooting dull ache burning stiff stabbing throbbing numb sore

Does your pain radiate (example: travel into arms, legs etc.) Yes No Where? _____

What time of day is your problem the worse (circle): morning afternoon evening during sleep

What treatment have you received for this condition: medication physical therapy surgery chiropractic
other _____ Did it help? Y N

#4. Additional Complaints (use back of sheet if needed)
