PEDIATRIC INTAKE FORM-PLEASE PRINT

Child's Full Name: ____

SSN#______________________________ Date: ___________________

Parent #1 Name: ____

Parent #2 Name____

Child's Home Address: ____

City: ________ State: ___ Zip:________ Home Telephone: _____________

Parent #1 Phone Work and/or Cell: ________________________________

Parent #2 Phone Work and/or Cell: ________________________________

Parent Email Address(es): _______________________________________

Whom may we thank for referring you? ______________________________

Has he/she ever had chiropractic care before? _________________________

For what problem? ____

ADOPTION INFORMATION

Child's Age When Adopted ________ Date of Adoption __________________

Known Health History of Child:

____

____

BIRTH INFORMATION

Birth Date _____________ Sex ______ Birth Weight ______ Birth Length _____

Current Age of Child _________ Type of Birth: Vaginal ___ Forceps ___

Breech ___ Cesarean ___ Home ____ Birthing Center ____ Hospital ____

Any problems during pregnancy and/or labor? If you need more space please attach an additional page for that information. ____________________________

____

APGAR Scores: ______ (1 min) _______ (5 mins)

Jaundice (yellow) at Birth? ________________ Cyanosis (blue)? ___________

Congenital Anomalies/Defects:

____

Infant Feeding: Breast _____ Bottle _____ Formula _____ Other Food or Drink

Information: ____

No. of Hours Child Sleeps Daily _____________________

Quality of Sleep: Good ________ Fair ___________ Poor __________

Explain:____

Number of Siblings _____ Siblings Name, Age and Sex: ___________________

____

HEALTH AND MEDICAL INFORMATION

Obstetrician and/or Midwife Name: ___________________________________

Location: ____

Pediatrician and/or Family MD Name: _________________________________

Location: ____

Date of Last Visit to Dr: _________ Purpose of that Visit: ___________________

Immunization History:

____

Has your child ever been treated on an emergency basis? ________________

Please Describe: ____

Purpose of the appointment today with the Chiropractor:

____

____

Developmental History

At What Age Did the Child: Age of the Child When Occurred:

Respond to Sound ___ Chicken Pox ___ Crawl ___ Rubella ___

Follow an Object with their Eyes ___ Rubeola __ Hold Head Up ___

Whooping Cough ___ Stand ___ Mumps ___ Sit Alone ___ Measles ___

Walk Alone ___ Other ____________________________________

Has this child ever suffered from (please circle any that apply): Allergies Anemia Arm Problems Arthritis Asthma Backaches Bed Wetting Behavioral Problems Blood Disorders Broken Bones Constipation/Diarrhea Colds/Flu Convulsions Diabetes Digestive Disorders Dizziness Chronic Ear Aches Fainting "Growing Pains Headaches Heart Trouble Hyperactivity Hypertension Joint Problems Leg Problems Muscle Jerking Neck Problems Neuritis Orthopedic Poor Appetite Paralysis Problems Rheumatic Fever Ruptures/Hernias Sinus Trouble Sleeping Problems Stomach Aches Sugar Concentration Tuberculosis Walking Problems Any Other Problems List Below:

____

Present Health History or Additional Information:

____

Surgery Information:

____

Medications:

____

Accidents:

____

Family Health History:

____

PERSONAL INJURY ONLY:

Accident Information: Is condition due to an accident? YES NO

Type: Auto work home other If this is due to an accident please notify the office to obtain the correct additional form

LIST ANY VISIBLE BUMPS, BRUISES, CUTS ETC. ON THE CHILD THAT WERE CAUSED BY THIS ACCIDENT?

____

INSURANCE Insured Name: ____________________________________

Ins. Company: ____

D.O.B.: ____

Group Number: ____

Relationship to patient: ____________________________

I.D. Number: ____

I certify that I and /or my dependants have insurance coverage with the insurance company listed above and assign directly to Active Living Health Center all insurance benefits if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance; I authorize the use of my signature on all insurance

submissions. The above named doctor may use my health care information and may disclose such information to the above named insurance company (ies) and their agents for the purpose of obtaining payment for service and determining insurance benefits or the benefits payable for related services. The consent will end when the current treatment plan or one year from the date signed below. ____________________________ (Print name of Patient Guardian or Personal Rep. Relationship to Patient) I understand and agree that Active Living Health Center has the right to refuse to accept my child as a patient at any time before treatment begins. The physical exam and x-rays are not considered treatment, but are part of the process of information gathering so the doctor can determine whether to accept my child as a patient. If x-rays or other studies are necessary before treatment begins I will be notified. I understand and agree that health and accident insurance policies are an agreement between the insurance carrier and myself, and that all services rendered to me are charged directly to me, and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

AUTHORIZATION OF CARE FOR A MINOR: I CERTIFY THAT THE INFORMATION ON THIS FORM IS TRUE TO THE BEST OF MY KNOWLEDGE I HEREBY AUTHORIZE THIS CLINIC AND IT'S DOCTOR(S) TO ADMINISTER CARE AS THEY SO DEEM NECESSARY TO MY SON/DAUGHTER/WARD (UPON APPROVAL OF PARENT OR GUARDIAN).

DATE: _____________________

PATIENT OR GUARDIAN SIGNATURE: _______________________________

FOR DOCTORS USE ONLY CC: ___________________________________

Location:____

Onset/Trauma: ____

Mechanism of Injury:____

Duration: ____

Current Symptoms: ____

Pain Numbness Stiffness Weakness other: ___________________________

Location: Left / Right / Bilateral

Quality of Symptoms: burning diffuse dull/aching localized radiating sharp shooting stabbing throbbing tightness tingling other:

____

Level of Impairment Due to Symptoms (resting): 0 1 2 3 4 5 6 7 8 9 10

Level of Impairment Due to Symptoms (with activity): 0 1 2 3 4 5 6 7 8 9 10

Worse in morning midday afternoon night activity rest Better in morning midday afternoon night activity rest Other Aggravating or Relieving Factors:

____

____

Present % during the day: 0% 10 20 30 40 50 60 70 80 90 100%

Visual Analogue Pain: 0 1 2 3 4 5 6 7 8 9 10 (best and worse)

Job Performance: mild (can do) moderate (limited ability) mod/severe (diff. limited duty) severe (can't do) Recreation: mild (can do) moderate (limited ability) mod/severe (diff. limited duty) severe (can't do) ADL's:

Past Health History:

Prior Interventions:

Paternal:

Maternal: