Pediatric Intake Form (3 years old to 12 years old)

Name: ______________________ Date: ______________________

Date of Birth: ________ / ________ / ________ (DD/MM/YYYY) Gender: ____________

Address: ______________________ City: ____________ Postal Code: ________

Name of Parents/Guardian: ______________________

Home Phone: ______________________ May we leave a message? ☐ Yes ☐ No

Parent's Work Phone: ______________________ May we leave a message? ☐ Yes ☐ No

Parent's Email (Your email address will not be shared): ______________________

Height of Child: ______________________ Weight of Child: ______________________

Are there any siblings? ☐ Yes ☐ No Age(s): ______________________

How did you hear about us? ______________________ Who can we thank for your referral? ____________

Emergency Contact

Name: ______________________ Phone: ______________________

Relationship to child: ______________________ Cell: ______________________

Family Doctor (Optional)

Name: ______________________ Phone: ______________________

Address: ______________________

Date of last appointment/physical: ______________________

Other Health Care Professionals (Optional) - (Medical Specialist, Naturopathic Doctor, Homeopath, Physiotherapist, Massage Therapist)

Name: ______________________ Phone: ______________________

Professional Designation: ______________________

Address: ______________________

Date of last appointment/physical: ______________________

Name: ______________________ Phone: ______________________

Professional Designation: ______________________

Address: ______________________

Date of last appointment/physical: ______________________

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Is your child currently taking any medication? ☐ Yes ☐ No

If yes, please specify: ______

Has your child taken any medications for extended period of time in the past? ☐ Yes ☐ No

If yes, please specify: ______

Is you child taking any herbal or vitamin supplements? ☐ Yes ☐ No

If yes, please specify: ______

Has your child received vaccinations? ☐ Yes ☐ No

Does your child receive exercise? ☐ Yes ☐ No

What complaint/concern brings you in? ______

How long has your child been experiencing this? ______

Is it getting better, worse, or staying the same? ______

Have you seen other health professionals regarding this complaint? ☐ Yes ☐ No

If yes, whom? ______

What treatment did they use? ______

Has your child taken medication for this complaint? ☐ Yes ☐ No

Has your child ever experienced this complaint before?” ☐ Yes ☐ No

Did they receive any treatment at this time? ☐ Yes ☐ No

Has your child had x-rays in relation to the current complaint? ☐ Yes ☐ No

Child Health History

Please CHECK anything which is currently causing your child problems/concerns.

Please CIRCLE anything which has been a problem/concern for your child in the past.

☐ Ear infections
☐ Chronic Colds
☐ Upper Respiratory Infections
☐ Digestive Problems
☐ Sinus Troubles
☐ Colic
☐ Neck Pains
☐ Scoliosis
☐ Headaches
☐ Allergies
☐ Diarrhea
☐ Recurring Fevers
☐ Growing Pains
☐ Back Pains
☐ Seizures
☐ Asthma
☐ Food Sensitivities
☐ Constipation
☐ Bed Wetting
☐ Eczema/Skin Irritation
☐ ADD/ADHD

Has your child experienced any of the following illnesses:

☐ Chicken Pox
☐ Rubella
☐ Whooping Cough
☐ Rubeola
☐ Mumps

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Developmental History

Has your child ever fallen from any high places? ☐ Yes ☐ No

Is/was your child ever involved in contact sports? ☐ Yes ☐ No

Has your child ever been involved in a motor vehicle accident? ☐ Yes ☐ No

Has your child ever been seen on an emergency basis? ☐ Yes ☐ No

Has your child ever broken and bones? ☐ Yes ☐ No

Has your child had any previous hospitalizations? ☐ Yes ☐ No

Has your child had any previous surgeries? ☐ Yes ☐ No

Prenatal History

Ultra-sounds during pregnancy: ☐ Yes ☐ No

Medications during pregnancy: ☐ Yes ☐ No

Medications during labour/delivery: ☐ Yes ☐ No

Were you induced? ☐ Yes ☐ No

Was your child at any time during pregnancy in an intra-uterine constraining position, such as:

☐ Breech ☐ Transverse ☐ Face/Brow presentation

Was your delivery vaginal or C-section? ____________________

If it was a C-section, was it planned or emergency? ____________________

Were any of the following used during delivery? ____________________

☐ Forceps ☐ Vacuum Extraction ☐ Other, please specify:

Were there any complications during delivery? ☐ Yes ☐ No If yes, please ____________________

Was your child breastfed? ☐ Yes ☐ No If yes, for how long? ____________________

What do you hope to achieve for your child by coming to Absolute Chiropractic?

____

Our primary goal is to work towards the resolution of you current condition as quickly as possible through excellent health care and patient education while helping to prevent you from experiencing this condition again. Do you have and specific concerns about the therapies that we provide?

____

____

We will always give a thorough explanation of what we've found in our history and physical exam; explain the condition we believe you to be suffering from as well as the treatment options available to you, the expected outcome and any risks involved. Always feel free to ask questions at any stage of your treatment, good communication is an important part of the treatment and prevention process at Absolute Chiropractic. I hereby authorize the health care professionals at Absolute Chiropractic with my prior knowledge, to release to or obtain any health information from other health care providers as may be required for the management of my case.

I have read and understood the Absolute Chiropractic fee schedule and cancellation policy. I am aware that if insurance claims are being submitted on my behalf that I am responsible for any outstanding balance not covered by my insurance policy.

Patient Signature: ____________________ Date: ____________________