# Pediatric Intake Form (2 years and under)



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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What complaint/concern brings you in? _____

Does your baby appear to be in pain or discomfort? _____

How long has your baby been experiencing this? _____

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

Was the onset sudden or gradual? _____

Have you seen other health professionals regarding this complaint? And if so whom? _____

_____

What treatment did they use? _____

Has your baby taken any medication for this complaint? ☐ Yes ☐ No

Has you baby ever experienced your complaint before? ☐ Yes ☐ No

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

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

Has your baby ever received chiropractic care previously? ☐ Yes ☐ No If yes, when? _____

Has your baby ever received massage therapy previously? ☐ Yes ☐ No If yes, when? _____

**Prenatal History**

Ultrasounds during pregnancy? ☐ Yes ☐ No

Medications during pregnancy? ☐ Yes ☐ No

Medications during labour/delivery? ☐ Yes ☐ No

Was Pitocin used to induce/speed up labour? ☐ Yes ☐ No

Were your membranes ruptured by a medical professional? ☐ Yes ☐ No

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

☐ Breech ☐ Transverse ☐ Face/Brow Presentation

Was your delivery vaginal or C-section? _____

If it was C-section, was it planned or emergency? _____

If it was vaginal, was the baby presented: ☐ Head ☐ Face ☐ Breech

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 specify: _____

How long was the labour from the first regular contractions to the birth? _____ Hour(s)

How long was the second stage (the pushing phase) of the labour? _____ Hours(s)

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**Post Natal History**

How many weeks at gestation was the baby at birth?_____

Birth Weight: _____ lbs. Birth Length: _____ Inches

If known, APGAR scores at: 1 minute: _____ /10 5 minutes: _____ /10

Baby's Crying: ☐ Cried immediately
☐ Cried strongly
☐ Cried weakly
☐ Did not cry for _____ minutes

Baby's Colour: ☐ Pink all over
☐ Blue face
☐ Blue hands/feet

Baby's Activity: ☐ Arms and legs actively moving
☐ Blue Face

Was the baby ever administered to Neonatal Intensive Care? ☐ Yes ☐ No

If yes, for how long and why?_____

Was any medication given to the baby at birth? ☐ Yes ☐ No

If yes, what medication and why?_____

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**Baby Health History**

How many hours does your baby sleep between feedings? Day: _____ Night: _____

Does your baby have a preferred sleeping position? ☐ Yes ☐ No _____

Does your baby have any feeding difficulties? ☐ Yes ☐ No

Is your baby currently being breast fed? ☐ Yes ☐ No

If no, how long was the baby breast fed? _____ weeks/months ☐ Not at all

Does your baby have a one-sided breast preference? ☐ Yes ☐ No

Does your baby cry often? ☐ Yes ☐ No Approximately how many hours a day? _____

Does your baby pass a lot of intestinal gas? ☐ Yes ☐ No

Does your baby frequently arch his/her head and neck backwards? ☐ Yes ☐ No

Is your baby currently taking any medication? ☐ Yes ☐ No If yes, please specify: _____

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

If yes, please specify: _____

Is your baby taking any herbal or vitamin supplementation? ☐ Yes ☐ No

If yes, please specify: _____

# Pediatric Intake Form (2 years and under)



**Developmental History**

| | | |
|---|---|---|
| Has your baby ever fallen from any high places? | ☐ Yes | ☐ No |
| Has your baby ever been involved in a motor vehicle accident or near miss? | ☐ Yes | ☐ No |
| Has your baby ever been seen on an emergency basis? | ☐ Yes | ☐ No |
| Has your baby ever broken any bones? | ☐ Yes | ☐ No |
| Has your baby had any previous hospitalizations? | ☐ Yes | ☐ No |
| Has your baby had any previous surgeries? | ☐ Yes | ☐ No |
| Have you chosen to vaccinate your child? | ☐ Yes | ☐ No |
| If yes, which vaccines have they received? | ☐ Yes | ☐ No |

DTaP-IPV ☐ Diptheria, Tetanus, Pertussis, Polio

MMR ☐ Measels, Mumps, Rubella

Var ☐ Varicella

HB ☐ Hepatitis B

Pneu ☐ Pneumococcal

Inf ☐ Influenza

Men ☐ Meningococcal

Describe any reactions your child has had to any vaccines: _____

_____

_____

_____

**Child Health History**

Please CHECK anything which is currently causing your baby problems/concern.

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

| | | |
|---|---|---|
| ☐ Ear Infections | ☐ Chronic Colds | ☐ Upper Respiratory Infections |
| ☐ Digestive Problems | ☐ Sinus Troubles | ☐ Colic |
| ☐ Allergies | ☐ Diarrhea | ☐ Recurring Fevers |
| ☐ Seizures | ☐ Asthma | ☐ Food Sensitivities |
| ☐ Constipation | ☐ Eczema | ☐ Skin Irritations |

Has your baby experienced any of the following illnesses:

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

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

Our primary goal is to work towards the resolution of your 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 any specific concerns about the therapies we provide?

We will always give a through 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 my 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.

Name of Child: _____ Date: _____

Parent/Guardian Signature: _____