Pediatric Intake Form

Date________________________ Referred By____

Patient Name____Phone Number__________________________

Address____

City____State________Zip_________________________

Birth Date_______________Sex________Weight_____________Height______SS#______________________

Names of Parents/Guardians____

Purpose for contacting us?____

Other doctors seen for this condition (if applicable)___________________________________

Treatment (if applicable)____

Check any of the following that pertains to your child:

- ☐ Ear Infections
- ☐ Asthma
- ☐ Allergies
- ☐ Colic
- ☐ Scoliosis
- ☐ Digestive Problems
- ☐ Bed Wetting
- ☐ Seizures
- ☐ Recurring Fevers
- ☐ Constipation
- ☐ ADHD
- ☐ Auto Accident
- ☐ A Fall
- ☐ Traumatic Birth
- ☐ Diarrhea
- ☐ Temper Tantrums
- ☐ Headaches
- ☐ Chronic Colds
- ☐ Adverse vaccination reaction
- ☐ Other____

Family History____

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Name of Pediatrician____________________________________Date of last visit_________________

Reason__________________________________Treatment____

Number of doses of antibiotics your child has taken:

1) In last 6 months:____
2) Total during his/her life:_____________________________________

Number of doses of other prescription medications your child has taken:

1) During last 6 months:____
2) Total during his/her life:_____________________________________

Vaccination history:____

Feeding History:

☐ Breast-fed If yes, how long?__________________ ☐ FormulaIf yes, how long?_________________

Introduced solids at _________months. Cow's milk at _________months.

Prenatal History:

☐ Complications during pregnancy? Explain____

☐ Ultrasounds during pregnancy? How many?____

☐ Medications during pregnancy/delivery? List them____

☐ Cigarette/alcohol use during pregnancy? Frequency____

Location of Birth ☐ Hospital ☐ Home ☐ Other____

Birth intervention ☐ Forceps ☐ Vacuum Extraction ☐ C-section

Delivery complications? ☐ No ☐ Yes____

Birth Weight____________________Birth Length________________________APGAR Scores___________

Childhood Diseases:

☐ Chicken Pox Age:_______ ☐ Rubeola Age:_______ ☐ Whooping Cough Age:_______

☐ Rubella Age:_______ ☐ Mumps Age:_______ ☐ Other______________________________

Developmental History:

At what age was your child able to:

Respond to sound ______________________ Crawl ____________________

Respond to visual stimuli ______________________ Stand Alone ____________________

Hold head up ______________________ Walk Alone ____________________

Sit ______________________

Has your child ever been involved in a car accident? ☐ No ☐ Yes (List)__________________________

Has your child ever fallen? ☐ No ☐ Yes (List)____

Prior surgery? ☐ No ☐ Yes (List)____

I hereby authorize Innate Living Chiropractic to administer care to my son/daughter. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Signed____Date________________________

Relationship to Patient____

Informed Consent for Chiropractic Care

When a person seeks the services of a chiropractor and we accept a patient for such care, it is essential for both parties to be working towards the same goals and objectives. It is important that such patient understand both the objective and the method that will be used to attain these goals as recommended by the Doctors at Innate Living Chiropractic. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care to be provided so that you may make the decision whether to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

We have one goal at Innate Living Chiropractic and that is to restore and maintain the integrity of the spinal cord and its nerve roots. These vital nerve pathways are located in and protected by the bones of the spine. Misalignments of the vertebrae (bones of the spine) which interfere with the function of these nerve pathways are called vertebral subluxations. Subluxations are caused by many of the things you do every day and keep your whole body from functioning properly. In children, the first subluxation is most often caused during the birthing process and/or bumps and falls associated with their growth and development. One thing remains true, large spine or small spine, if the spine is causing stress on the nervous system, it may lead to a body which does not run optimally. The removal of the subluxation results in a better expression of health and vitality in your child so that he/she may reach their full innate potential during their development.

Consequently, the objective of the Doctors at Innate Living Chiropractic is to provide a chiropractic adjustment to correct subluxation thereby restoring normal nerve function. It is not the objective or intention of Innate Living Chiropractic to fix, treat, or attempt to cure any physical, mental, or emotional ailments or to give advice on said ailments. With a proper nerve supply your whole body is better able to reach its full innate potential and to express more life.

If during the course of care, we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my child's care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction.

I,________________________________being the parent or legal guardian of _______________________________ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive Chiropractic care.

_______________________________________ ___________________________________

Signature of Parent/Legal Guardian Date