WHOLE HEALING CHIROPRACTIC & ACUPUNCTURE
Pediatric Chiropractic Intake Form -Birth to Two Years

Patient (Child) Information:

Name: _____

Address: _____

Sex: ___Male ___Female Date of Birth: _____ Height: _____ Weight: _____

Name of Parents/Guardians: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____

How did you hear about us? _____

What is your primary goal for your child at our clinic? _____

_____

Is there a specific concern that brings you in? Y N

N - I would like my child's nervous system assessed to achieve optimal health and functioning.

Y - Explain _____

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: _____

Childs current medications: _____

_____

Pregnancy/Birth History:

1- Did mother smoke during pregnancy? Y N **2**- Did mother use alcohol during pregnancy: Y N

3- Did mother have any of the following during pregnancy:

___High or Low Blood pressure ___Heart Problems ___Swollen Ankles ___Thyroid Problems ___Diabetes

___Anemia ___Back Pain ___Abnormal Bleeding ___Morning Sickness ___Indigestion ___Premature Contractions

4- Any complications during pregnancy? Y N Explain: _____

5- Was mother hospitalized during pregnancy? Y N Explain: _____

6- Did mother have any accidents or falls during pregnancy? Y N Explain: _____

7- Medications taken during pregnancy: _____

8- Was Child: ____Premature ____Full Term **9**- Any Birth Intervention: ___Forceps ___Vacuum ___C-Section

10- Complications during delivery? Y N Explain: _____

11- Place of birth _____ **12**- Mother's medications during birth _____

13- Child's birth weight: _____ **14**- Childs birth length: _____

15- Was intensive care needed? Y N If yes how long? _____

Feeding History:

16- Breast Fed: Y N How long: _____ **17**- Formula Fed: Y N How long: _____

18- Introduced to Solids at _____ Months & to Cow's milk at _____ Months

19- Does/did the child spit up frequently? Y N

20- Did/does the child suffer from: ___colic ___reflux ___constipation ___diarrhea ___gas

21- How would you rate your child's diet? ___Well-Balanced ___Average ___High sugar/processed foods

22- Food Allergies or Intolerances? Y N Explain: _____

23- Does your child consume artificial sweeteners? Y N

24- Is your child a picky eater? Y N Explain: _____

25- Does your child take any vitamin supplements? Y N Explain: _____

Childhood Diseases:

26- Did the child have any of these childhood diseases?

Chicken Pox: Y N Age: _____ Rubella: Y N Age: _____

Rubeola: Y N Age: _____ Mumps: Y N Age: _____

Whooping Cough: Y N Age: _____ Other: _____ Age: _____

Developmental History:

27- At what age was your child able to do the following?

_____ Respond to Sound _____ Crawl

_____ Respond to Visual Stimuli _____ Stand Alone

_____ Hold Head Up Alone _____ Walk Alone

_____ Sit Up Alone _____ Talk

28- Any childhood falls head first from a high place during their first year of life (i.e.: a bed, changing table, down stairs, etc.)? Y N Explain: _____

29- Is/has your child been involved in any high-impact or contact type of sports (i.e.: soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.)? Y N Explain: _____

30- Has your child had any major injuries? Y N Explain: _____

31- Has your child ever been involved in a car accident? Y N Explain: _____

32- Other traumas not described above? Y N Explain: _____

33- Prior surgeries? Y N Explain: _____

34- Genetic disorders or disabilities: _____

35- How many times has your child been prescribed antibiotics in the past 6 months? _____

Total during lifetime: _____

36- Has your child received vaccinations? Y N Any adverse reactions? _____

Review of Systems/General Questions:

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

___Headaches ___Postural Imbalances ___Growing Pains ___Scoliosis ___Tonsillitis

___Asthma ___Torticollis ___Ear Infections ___Seizures ___Sleep Problems ___Bedwetting

___Digestive Problems ___Constipation ___Diarrhea ___Anxiety ___Autism ___ADHD

___Frequent Fever ___Colic ___Learning Difficulties ___Acid Reflux ___Hip Dysplasia ___Allergies

___Skin Problems ___Back/Neck Pain ___Pain In Arms/Legs ___Trips/Falls Easily

38- Any behavioral, social or emotional issues? _____

_____

39- Does/did your child have frequent temper tantrums? Y N

40- Does/did your child cry a lot? Y N

41- How many hours a day does your child typically spend watching TV, computer, tablet or phone? _____

42- Does the child go to sleep easily? Y N

43- Number of hours your child sleeps: _____ hours per night _____hours per day/naps

44- Sleep Quality: ___Good ___Fair ___Poor

45- How many children are in your household? _____

Relationships & Ages_____

46- Does your child go to daycare? Y N

47- Is there a smoker in your house? Y N

48- Childs parents are: ___Married ___Living together ___Separated ___Divorced ___Widowed

49- Other difficulties in the home or home life that could be affecting the child?

(i.e-Physical/environmental/mental/emotional/unavoidable etc)

_____

_____

50- Anything else we should know? _____

_____

_____