**Pediatric Patient Intake Form**

**Patient name**: Click here to enter Patient Name. Age: Age. Birth Date: Birthday.

Address: Street. , City. State: Choose an item. Zip Code: Zip.

Name of Parents/Guardians: Parent/Guardian Name.

Parents Phone: Parent Primary Phone. Type: Choose an item.Choose an owner.

Email: Email.

Referred By: Contact.

Would you like this office to verify your health insurance coverage?  No Yes

**Consultation**

Reason for seeking chiropractic care: Complaint.

When did the problem begin: Click here to enter a date.

Is this problem  Occasional  Frequent  Constant  Intermittent

If the pain travels, where does it go? Location.

What makes it better? Ice, Rest, Stretching, etc.

What makes it worse? Ice, Rest, Stretching, etc.

Is the problem worse during a certain time of the day?  No  Yes If YES, when?

Does this interfere with the child’s  Sleep  Eating  Digestion  Daily Routine

Is this becoming worse?  No  Yes If YES, how?

Other professionals seen for this condition?  No  Yes If YES, who?

Results with treatment? Results.

**Prenatal History for Infants and Newborns**

Name of Obstetrician/Midwife Name.

Complications during pregnancy:  No  Yes If YES, list

Birth Intervention:  Forceps  Vacuum  Caesarian: *Planned or  Emergency*

Complications during delivery:  No  Yes If YES, describe.

Medications during pregnancy:  No  Yes If YES, list.

Cigarette /Alcohol use during pregnancy:  No  Yes

Was the infant alert and responsive within 12 hours of delivery?  No  Yes If NO, please explain.

Birth Weight Weight. Birth Length Length. APGAR scores Scores.

Genetic disorders or disabilities? If YES, list/explain.

Breast Fed: No  Yes How Long? Formula Fed:  No  Yes How Long? Solids at Choose an item.months

Food/Juice allergies or intolerances  No  Yes If YES, list.

At what age did the child: Respond to sound Choose an item. Follow an object Choose an item. Hold head up Choose an item. Vocalize Choose an item. Sit alone Choose an item. Crawl Choose an item. Walk Choose an item. Sleep Through Night Choose an item.

**Medication History**

Previous Chiropractor: Dr.’s Name. Date of last visit & Reason: Click here to enter a date. Reason.

Name of Pediatrician: Dr.’s Name. Date of last visit & Reason: Click here to enter a date. Reason.

Are you satisfied with the care your child receives there? Yes No

Immunization History: History. Reactions: Reactions.

Check all drugs your child is taking including prescription and non-prescription drug

Asthma medication  Tylenol  Advil/Ibuprofen  Cold tablets  Allergy Med

ADHD Med  Painkillers  Anti-Depressants  Other Other...

Does your child take any Vitamins or Herbs?  No  Yes If Yes, list.

Number of antibiotics your child has taken: Past 6 months 6 months. Total during his/her lifetime Lifetime.

**Falls & Injuries**

According to the National Safety Council, 50% of children fall head first from a high place during their first year of life (i.e. a bed, changing table, down stairs, etc)

Is this the case with your child?  No  Yes

When was your child’s most recent fall? Click here to enter a date. What happened? What Happened?

Which of the following sports have your child been involved in?

Football  Basketball  Soccer  Gymnastics/Cheerleading  Martial Arts  Baseball

Running  Horseback riding  Other: Other...

Has your child ever broken a bone?  No  Yes If YES, which one(s).

Has your child ever been involved in an auto accident?  No  Yes Was there an impact?  No  Yes

Were there injuries?  No  Yes If YES, Date/any treatment.

Has your child ever been seen on an emergency basis?  No  Yes If YES, please list all.

Other traumas not described above?  No  Yes If YES, please list.

Prior surgery:  No  Yes If Yes, date and type. Menses:  No  Yes Age: Age.

**Childhood Diseases & Illness**

|  |  |  |  |
| --- | --- | --- | --- |
| Acid Reflux | ADD/ADHD | Allergies | Anemia |
| Arthritis | Asthma | Autism | Backaches |
| Bed Wetting | Behavioral Problems | Blood Disorders | Broken Bones |
| Bronchitis | Car Accident | Chicken Pox | Chronic Colds |
| Chronic Ear aches | Colic | Constipation | Convulsions |
| Depression | Diabetes | Diarrhea | Digestive Problems |
| Dizziness | Ear Infection | Epilepsy | Fainting |
| Fatigue | Growing Pains | Headaches | Heart Trouble |
| Hernias | Hyperactivity | Hypertension | Jaundice |
| Loss of Balance | Loss of Smell | Mumps | Neck Pains |
| Poor Appetite | Poor Coordination | Recurring Fevers | Rubella |
| Scoliosis | Seizures | Shortness of Breath | Sinus |
| Sore Throats | Stomach Aches | Temper Tantrums | Urinary Problems |
| Walking Problems | Whooping Cough | Other: | |

Authorization To Treat A minor

I Name. , Parent or legal Guardian of Child’s Name. .

Hereby authorize Ed Osgood, D.C., Jocelyn Wertz, D.C., and his staff to administer chiropractic care to my son or daughter as they deem necessary. As of this date, I have the legal right to select and authorize health care services for the minor child. Under the terms and conditions of my marriage, divorce, separation, or other legal authorization the consent of a spouse/former spouse or other parents is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office. • I acknowledge and approve for my electronic signature to be considered the same as my written signature.

Signature of Parent/Guardian Click here to enter text. Date: Click here to enter a date.