Pediatric Intake Form (Birth to 12 years)

Date: ___/___/_____
Child's Name: ____ DOB: ___/___/_____
Parent's/Guardian's Names: ____
Phone numbers: (H) ________________ (C) ______________ Best number to reach you? □ **H** □ **C**
Address: ____
E-Mail Address: ______________________________@__________________________
Has your child been checked by a Doctor of Chiropractic? □ **Yes** □ **No** Name: ________________________
Were x-rays taken? □ **Yes** □ **No** Who is your medical pediatrician?________________________________

Prenatal History

Is your child adopted? □ **Yes** □ **No**
Did you have any complications and when? ____
Did you smoke/consume alcohol? □ **Yes** □ **No**
Did you take medication? □ **Yes** □ **No** Reason: ____

Birth history

Did you have ultrasound during this pregnancy? □ **Yes** □ **No** Frequency___________________________________
Place of birth: Home/ Birthing Center/ Hospital
Provider: □ Midwife □ OB-Gyn/ □ Other (Name): ____
Type of Birth: Vaginal / C-section. Were pain medications used? □ **Yes** □ **No** Type ______________________
Was labor induced? □ Yes □ No If yes, why? ____
What position did you deliver in: □ Squatting □ On Back □ Other ____
Birth Trauma: □ Doctor assisted □ Twisting and/or Pulling □ Vacuum Extraction □ Forceps
Newborn trauma (medical procedures and tests): ____
APGAR score: at birth ___ /10 at 5-minutes ___ /10 □ Unsure
Did your child have a misshaped skull/head? □ **Yes** □ **No** Purple markings on their face? □ **Yes** □ **No**

Do you/Did you breastfeed your child? □ Yes □ No If yes, for how long?_________________________________
Does your child prefer one breast/side over the other? □ Yes □ No Side: □ Right □ Left
Does your child have any food or other allergies? (list) ____

Has your child been immunized according to the recommended schedule? □ Yes □ No
Reason for vaccination: informed decision, didn't know had a choice, recommended
Did your child have any negative reactions to vaccinations? □ Yes □ No ___________________________________
Were they reported? □ Yes □ No

Has your child ever had any surgeries? □ Yes □ No Please explain: ______________________________________
Have they been on antibiotics? □ Yes □ No How many times? ________ Reason: ______________________
Is your child currently taking any meds? □ Yes □ No ____
Any vitamins? □ Yes □ No ____

Baby/Toddler (0-4): have/did any of the following occur?

□ Fall from a changing table □ Frequent crying spells
□ Tumble down stairs □ Frequent fevers
□ Fall out of crib □ Frequent bouts of diarrhea
□ Involvement in MVA □ Constipation
□ Fall off of playground equip □ Sleeping problems
□ Play in a Johnny jumper □ Repeated infections or colds
□ Frequent ear infections □ Colic
□ Tonsillitis □ Inadequate weight gain
□ Reaction to vaccines □ Other: ____________________
Please explain: ____
____

Child (5-12): have/did any of the following occur?

- □ Fall from a tree
- □ Fall on playground
- □ Fall off of a bicycle
- □ Hyperactivity/autism
- □ Sports accident
- □ Learning difficulties
- □ Car accident
- □ Asthma
- □ Stomach pains
- □ Allergies
- □ Scoliosis
- □ Leg/knee pains
- □ Bed wetting
- □ Other: _______________________

Please explain: ____
____

Which of the above bothers your child the most? ____
When did it begin? _________________________ Is it getting worse? □ Yes □ No
Is the pain: □ constant □ intermit □ cyclic
How much has the complaint affect daily activities/routines? □ Not at all □ Somewhat □ Frequently □ Always

Which sports does your child play? □ Soccer □ Football □ Gymnastics □ Karate □ Hockey □ Lacrosse .
□ Basketball □ Dance □ Wrestling □ Baseball/ Softball □ Volleyball □ Tennis □ Swimming □ Rugby
□ Other: ____

How would you rate your child's diet? □ *Well balanced* □ *Average* □ *High amounts sugar & processed food*
Does your child consume artificial sweeteners? □ Yes □ No Flouridated water? □ Yes □ No
Number of hours your child sleeps? ____/day Quality: □ Good □ Fair □ Poor

Is there anything else we should know about your child? ____
____

Authorization to Treat a Minor

I, _______________________________ the undersigning parent/person having legal custody/guardianship of ____________________________, a minor, do hereby authorize, request and direct Drs. Skow and/or Murray and whomever he/she may designate as assistant to perform in judgment any examination and chiropractic diagnosis or treatment which is deemed necessary.

Any specific written authorization you provide may be revoked at any time by writing to us at the address provided at the end of this notice.

PATIENT: ____ Date of Birth: __________________
Name (Print) Social Security #: _______________
Signature: ____ Date: _________________________
Parent/Legal guardian

Insurance Information

Insured's Name: ____

Date of Birth: _____/_____/______ SS#: ______________________

Relationship to patient: ____________________________________

Insured's Employer: ____

Insurance Company: □ BC/BS (PPO) □ Medicare □ Coventry □ United Health Care □ Other:_____________________

Insurance ID#: ____

Group #: ______________ Plan/Program: _____________________

Assignment and Release: I certify that I, and/or my dependent(s), have insurance coverage with above insurance company and assign directly to Valerie Skow/Lindsey Murray all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named doctor/facility may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

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SIGNATURE **PRINT**
Name of Patient, Parent, Guardian or Personal Representative

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