HEARTLAND
CHIROPRACTIC + WELLNESS CENTER

Pediatric Intake Form
(Birth to 12 years)

Child's Name: ____________________________________ DOB: ___/___/___ Sex: M / F Today's Date: ___/___/_____

Parent's/Guardian's Names: ____

Phone numbers: (H) _____________________ (C) _____________________ E-Mail: ______________________________

Address:_______________________________________City_____________________State_______Zip_________________

Has your child been checked by a Doctor of Chiropractic? ☐ **Yes** ☐ **No** Name: __________________________________

Were x-rays taken? ☐ **Yes** ☐ **No** Who is your medical pediatrician?____

How did you hear about us? Referral Name: ____

Local: Johnston Living, Dex or Yellow Book Internet Search: Google / Bing / Yahoo / Other:__________

Prenatal History:

Is your child adopted? ☐ **Yes** ☐ **No**

Did you have any prenatal complications and when? ____

Did you smoke/consume alcohol during pregnancy? ☐ **Yes** ☐ **No**

Did you take medication during pregnancy? ☐ **Yes** ☐ **No** Reason: ____

Did you have ultrasound during this pregnancy? ☐ **Yes** ☐ **No** Frequency____

Birth History:

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 ☐ **U**nsure

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 ☐ Frequent fevers ☐ Colic ☐ Tumble down stairs

☐ Fall out of crib ☐ Involvement in MVA ☐ Tonsillitis ☐ Constipation ☐ Repeated infections or colds

☐ Fall off of playground equip ☐ Sleeping problems ☐ Inadequate weight gain ☐ Reaction to vaccines

☐ Frequent ear infections ☐ Play in a Johnny jumper ☐ Frequent bouts of diarrhea

☐ Other: ______________________Please explain: ____

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

☐ Fall from a tree ☐ Fall on playground ☐ Scoliosis ☐ Leg/knee pains ☐ Fall off of a bicycle

☐ Hyperactivity/autism ☐ Car accident ☐ Asthma ☐ Sports accident ☐ Learning difficulties

☐ Stomach pains ☐ Allergies ☐ 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** Fluoridated 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 O'Donnell/Davis and whomever he/she may designate as assistant to perform in judgment any examination and chiropractic diagnosis or treatment which is deemed necessary, including but not limited to HCWC massage therapist(s) and staff.

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: __________________ Social Security #: _______________
Name (Print)

Signature: ____ Date: _________________________
Parent/Legal guardian

Insurance Information

*** If you would like to consider our Time of Service (Cash) Plan please request information at the front desk.**

Insured's Name: ____ Relationship to patient: _______________________________________

Date of Birth: _____/_____/______ SS#: ______________________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/Juliet O'Donnell/Tyler Davis 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*.

Signature ____ Print____