Record	#		
IXCCOIU	TT		



PEDIATRIC INTAKE FORM (0-10)

			_
Name			
Guardian Name			
Address			
Home Phone Cell Phone	E-Mail		
Gender □ M □ F Have they been to a chiropractor before?			
Who May We Thank For Referring You To Our Office:			
DDECENT COMPLAINTS DE CHELL	1 1 . 1		
PRESENT COMPLAINTS Please fill out in	as much detail as pos	ssible	
#1	How lone	a has this boon ar	nicouo?
πι		y nas uns been ar	1 135ue :
➤ TIMING: ☐ Constant (100%) ☐ Frequent (50-75%)	☐ Occasional (25-50%)	☐ Intermittent (1-259	%)
➤ WORSE AT: ☐ Morning ☐ Mid-day ☐ Night ☐ Va	·	(==,	~)
➤ FEELS LIKE: □ Dull □ Sharp □ Ache □ Stabbin		☐ Other	
➤ DOES IT RADIATE? □ No □ Yes, to:	· ·		
➤ IT IS: ☐ Staying the same ☐ Getting worse ☐ Imp	proving		
> PAIN SCALE (right now as you fill this out): NO	PAIN 0-1-2-3-4-5	5 - 6 - 7 - 8 - 9 - 10	WORST PAIN
> PAIN SCALE (when it is at its worst): NO	PAIN 0-1-2-3-4-5	5 - 6 - 7 - 8 - 9 - 10	WORST PAIN
> RELIEVED BY:			
▶ PREVIOUS EPISODES: ☐ No ☐ Yes; details:			
▶ PREVIOUS CARE FOR THIS CONDITION? □ No	☐ Yes:		
➤ RECENT TESTING? □ No □ Yes:			

#2	How long	g has this been ar	ı issue?
TIMING: Constant (4000) D Fraguent (50.750)	□ Occasional (25 50%)	□ Intermittent (1.250	v/ \
 ➤ <u>TIMING</u>: □ Constant (100%) □ Frequent (50-75%) ➤ <u>WORSE AT</u>: □ Morning □ Mid-day □ Night □ Va 		intermittent (1-25)	70)
 WORSE AT: ☐ Morning ☐ Mid-day ☐ Night ☐ Va FEELS LIKE: ☐ Dull ☐ Sharp ☐ Ache ☐ Stabbin 		☐ Other	
➤ DOES IT RADIATE? □ No □ Yes, to:	•	Other	
► IT IS: □ Staying the same □ Getting worse □ Imp			
> PAIN SCALE (right now as you fill this out): NO	•	5 – 6 – 7 – 8 – 9 – 10	WORST PAIN
	PAIN 0-1-2-3-4-5		
> RELIEVED BY:	Control of the Contro		
➤ PREVIOUS EPISODES: □ No □ Yes; details:	100000000000000000000000000000000000000		ork all areas of concern:
➤ PREVIOUS CARE FOR THIS CONDITION? □ No			
➤ RECENT TESTING? □ No □ Yes:			
		(NA)	(3 (11)
Any other information the doctor should know:		1000) 5 11 (11
		11 x 11	11
		4 p	() ()
) () (2 3/
DOCTORS NOTES:		\0(5 (\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \
·		DIS	1, 510
Patient/Guardian Signature Date	e Dr. Sig	gnature	Date

Record #



<u>PATIE</u>						
	ENT HISTORY					
M ON E	MEDICAL PROBLEMS - No prior	history of any significant i	medical problems: Initial:			
Mark the	e conditions that apply to you:					
Past P	Present	Past Pres	sent	Past	Pre	sent
	□ Headaches		Vision Problems			Dizziness/Fainting
	□ Ear Infections		Sleeping Problems			Neck Issues
	□ Colic		Growing Pains			Back Issues
	□ Allergies / Asthma		Dental Problems			Arm/Leg Issues
	■ Medication Side Effects		Temper Tantrums			Reflux
	Recurring Fevers		ADHD			Constipation
	Digestive problems		Seizures			Diarrhea
	□ Bed Wetting		Scoliosis			Poor Posture
	Chronic Colds/SinusOther		Ever Needed Stitches			
	☐ Cancer (please give details):					
Name of Location Yes Yes Yes Yes Yes Yes Yes Yes Yes Ye	 □ No Complications during prediction □ No Ultrasounds during prediction □ No Medication during prediction □ No Cigarette/alcohol use 	e: Home thing Center	any?::			
	describe any past conditions and					
Please li	list any past hospitalizations and	surgeries				
Mother's	s side: Heart Disease Cancers side: Heart Disease Cancers any other family history you wan	er 🗆 Diabetes 🗆 Heavy	Medication use Arthritis	□ Other		



Patient Name

Date _____

Is Your Child Trying to Tell You Something?

Check off all that apply:

Impulsive Aggression Withdrawal Cannot sit still Can't follow instructions Rocking/head banging Temper tantrums/meltdowns Reckless, can't control actions Bites nails, picks or cuts skin Damages property Eating Disorders Develops physical symptoms in response to emotional issues Social phobia/other phobias Inappropriate feelings Inability to sleep Light/sound sensitivity Tics, constant movement Fearful of crowds, strangers, new environment, altered routine Trouble with non-verbal cues Clumsy/poor coordination Developmental delays Lack of social skills Skills Skills Lack of social skills Lack of s	Defiant No care for consequences Overly self-conscious Detached from family Unable to handle disappointment Lack of respect to parents, teachers Difficulty making friends Distorted thinking Deceitfulness Easily distracted Anti-social Difficulty concentrating Learning disability (dyslexia, ADHD, etc.) Difficulty with logic/reasoning Poor executive brain function Asthma Lost interest in school Language delays Frequent/prolonged illness Poor memory Headaches, stomach-aches, joint pains, fatigue Severe reactions to minor infections Auto-immune problems (cancer, lupus, diabetes, etc.) Chronic cough/runny nose Skin conditions Allergies Allergies Allergies

Patient/Guardian Signature	Date	Dr. Signature	Date
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Record #	
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Patient Name			Date		
n your own words, please tell us more about your child and the signs they have been exhibiting:					
Patient/Guardian Signature	Date	Dr. Signature	Date		