Taylor Family CHIROPRACTIC

Record # _____

PEDIATRIC INTAKE FORM (0-10)

Name _____ **Today's Date**_____ **Birthdate** _____ **Age**_____

Guardian Name _____ **# of kids / ages** _____

Address _____ **City** _____ **State** _____ **Zip** _____

Home Phone _____ **Cell Phone** _____ **E-Mail** _____

Gender ❑ **M** ❑ **F** **Have they been to a chiropractor before?** □ **Yes** □ **No**

Who May We Thank For Referring You To Our Office: _____

PRESENT COMPLAINTS

Please fill out in as much detail as possible

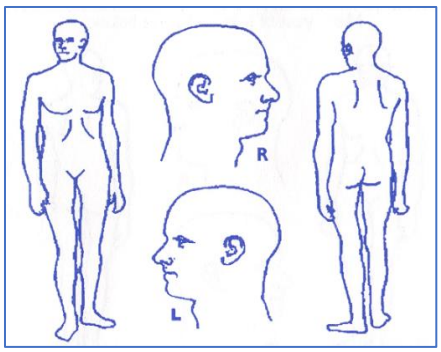
#1._____ **How long has this been an issue?** _____

- **TIMING:** ❑ Constant (100%) ❑ Frequent (50-75%) ❑ Occasional (25-50%) ❑ Intermittent (1-25%)
- **WORSE AT**: ❑ Morning ❑ Mid-day ❑ Night ❑ Varies
- **FEELS LIKE:** ❑ Dull ❑ Sharp ❑ Ache ❑ Stabbing ❑ Numb/Tingle ❑ Burn ❑ Other _____
- **DOES IT RADIATE?** ❑ No ❑ Yes, to:_____
- **IT IS:** ❑ Staying the same ❑ Getting worse ❑ Improving
- **PAIN SCALE (right now as you fill this out):** **NO PAIN 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 WORST PAIN**
- **PAIN SCALE (when it is at its worst):** **NO PAIN 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 WORST PAIN**
- **RELIEVED BY:** _____ **AGGRAVATED BY:** _____
- **PREVIOUS EPISODES:** ❑ No ❑ Yes; details:_____
- **PREVIOUS CARE FOR THIS CONDITION?** ❑ No ❑ Yes: _____
- **RECENT TESTING?** ❑ No ❑ Yes: _____

#2._____ **How long has this been an issue?** _____

- **TIMING:** ❑ Constant (100%) ❑ Frequent (50-75%) ❑ Occasional (25-50%) ❑ Intermittent (1-25%)
- **WORSE AT**: ❑ Morning ❑ Mid-day ❑ Night ❑ Varies
- **FEELS LIKE:** ❑ Dull ❑ Sharp ❑ Ache ❑ Stabbing ❑ Numb/Tingle ❑ Burn ❑ Other _____
- **DOES IT RADIATE?** ❑ No ❑ Yes, to:_____
- **IT IS:** ❑ Staying the same ❑ Getting worse ❑ Improving
- **PAIN SCALE (right now as you fill this out):** **NO PAIN 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 WORST PAIN**
- **PAIN SCALE (when it is at its worst):** **NO PAIN 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 WORST PAIN**
- **RELIEVED BY:** _____ **AGGRAVATED BY:** _____
- **PREVIOUS EPISODES:** ❑ No ❑ Yes; details:_____
- **PREVIOUS CARE FOR THIS CONDITION?** ❑ No ❑ Yes: _____
- **RECENT TESTING?** ❑ No ❑ Yes: _____

Please mark all areas of concern:



Any other information the doctor should know:

_____

_____

_____

DOCTORS NOTES: _____

_____

_____

Patient/Guardian Signature _____ Date _____ Dr. Signature_____Date_____

Taylor Family CHIROPRACTIC

Record # _____

Patient Name_____ **Date** _____

PATIENT HISTORY

❑ **NO MEDICAL PROBLEMS - No prior history of any significant medical problems: Initial:_____**

Mark the conditions that apply to you:

Past	Present		Past	Present		Past	Present	
❑	❑	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/Sinus	❑	❑	Ever Needed Stitches			
❑	❑	Other _____						
❑	❑	Cancer (please give details): _____						

List any medications being taken:_____

Number of courses of antibiotics child has taken in the last 6 months.:_____ Total during lifetime:_____

Birth Weight:: _____ Current Weight:_____

Date of last pediatrician Visit: _____/_____/_____ Reason:_____

Name of pediatrician/obstetrician/midwife: _____

Location of Birth: ❑ Hospital ❑ Birthing Center ❑ Home

❑ Yes ❑ No Complications during pregnancy Details:_____

❑ Yes ❑ No Ultrasounds during pregnancy How Many?:_____

❑ Yes ❑ No Medication during pregnancy/delivery List:_____

❑ Yes ❑ No Cigarette/alcohol use during pregnancy Details:_____

❑ Yes ❑ No Any past auto collisions and care received _____

❑ Yes ❑ No Any past falls/bumps/bruises _____

❑ Yes ❑ No Any past sport, recreational, or home injuries _____

Please describe any past conditions and treatment received _____

_____

Please list any past hospitalizations and surgeries _____

_____

Father's side: □ Heart Disease □ Cancer □ Diabetes □ Heavy Medication use □ Arthritis □ Other_____

Mother's side: □ Heart Disease □ Cancer □ Diabetes □ Heavy Medication use □ Arthritis □ Other_____

Is there any other family history you want us to know? _____

Patient/Guardian Signature _____ Date _____ Dr. Signature_____Date_____

Taylor Family CHIROPRACTIC

Record # _____

Patient Name _____ Date _____

Is Your Child Trying to Tell You Something?

Check off all that apply:

Patient/Guardian Signature _____ Date _____ Dr. Signature_____Date_____

Taylor Family
CHIROPRACTIC

Record # _____

Patient Name _____ Date _____

In your own words, please tell us more about your child and the signs they have been exhibiting:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Patient/Guardian Signature _____ Date _____ Dr. Signature_____Date_____