Chiropractic Neurology & Wellness Center

Pediatric Intake Form

PLEASE PRINT CLEARLY

Todays Date: _____

Child's Name: _____ Gender: _____

Age _____ Date of Birth: _____

Mother's Name: _____

Mother's Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Cell: _____ E-mail _____

Work Status: ☐ Employed ☐ Retired ☐ Disabled ☐ Student School Name: _____

Occupation: _____

Employer: _____ Work Phone: _____

Employer Address: _____ City: _____ State:___ Zip: _____

Father's Name: _____

Father's Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Cell: _____ E-mail _____

Work Status: ☐ Employed ☐ Retired ☐ Disabled ☐ Student School Name: _____

Occupation: _____

Employer: _____ Work Phone: _____

Employer Address: _____ City: _____ State:___ Zip: _____

Parental Social Security Number: _____ ☐ Mother ☐ Father

Please list your other children and their ages:

1. _____ 3. _____

2. _____ 4. _____

Emergency Contact: _____ Phone Number: _____

How were you referred to our office? _____

Purpose of Visit

Why is your child here today? _____

_____

When did the condition begin? _____

Does anything improve the condition? _____

What makes the condition worse? _____

Has your child seen his/her pediatrician for this complaint? ☐ Yes ☐ No

Pediatrician Name: _____

Other practitioners (specialists, chiropractors, acupuncturist, etc.) your child has seen for this complaint:

1. _____ 3. _____

2. _____ 4. _____

Are you satisfied with any of the care you received? ☐ Yes ☐ No If no please explain: _____

_____

Prenatal History

Name of Obstetrician/Midwife: _____

Complications during pregnancy? _____

Medications during pregnancy? _____

Cigarette/Alcohol use during pregnancy? ☐ Yes ☐ No Second hand smoke exposure during pregnancy? ☐ Yes ☐ No

Birth History

Place of birth: ☐ Hospital ☐ Home ☐ Birthing Center ☐ Other: _____

Birth Intervention: ☐ Forceps ☐ Vacuum Extraction ☐ C-Section

Birth Weight: _____ lbs. Length: _____" APGAR: _____ Genetic Disorder/Disability? ☐ Yes ☐ No

Feeding History:

Breast Fed? ☐ Yes ☐ No How long: _____ Formula fed? ☐ Yes ☐ No How long: _____ Type: _____

Food/Fluid Intolerance? _____

Food Allergies? _____

Vaccination History: ☐ Declined to vaccinate at this time

Hepatitis B	☐ Yes ☐ No	Rotavirus	☐ Yes ☐ No	DPT	☐ Yes ☐ No	Influenza	☐ Yes ☐ No
Varicella	☐ Yes ☐ No	Hepatitis A	☐ Yes ☐ No	MMR	☐ Yes ☐ No		
Meningococcal	☐ Yes ☐ No	Pneumococcal	☐ Yes ☐ No	Polio	☐ Yes ☐ No		

Did your child suffer from any of the following adverse reactions following the vaccinations?

☐ Fever ☐ Vomit ☐ Seizure ☐ Swelling ☐ Lethargy ☐ Paralysis

☐ Other: _____

Developmental History:

Please provide the approximate age of your child when he/she reached the following milestones:

Responded to sound: _____ Responded to visual stimulus: _____

Held head up: _____ Sat independently: _____

Crawled: _____ Stood independently: _____

Walked: _____

Has your child ever experienced a significant fall, loss of consciousness or been involved in an automobile accident? If yes, please explain: _____

Has your child been seen on an emergency visit? ☐ Yes ☐ No If yes, for what? _____

_____

Has your child undergone any surgery? ☐ Yes ☐ No If yes, for what? _____

_____

Daily Habits:

How many hours of sleep/night? ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9+ Rate the quality of sleep: ☐ Poor ☐ Fair ☐ Good ☐ Excellent

Does your child take probiotics? ☐ Yes ☐ No Does your child take Omega-3 (fish oil) daily? ☐ Yes ☐ No

Please list any other supplements/vitamins your child takes:

1. _____ 3. _____

2. _____ 4. _____

Please list any medication your child takes:

1. _____ 3. _____

2. _____ 4. _____

Diet: ☐ Vegetarian ☐ Vegan ☐ Everything ☐ Very Picky ☐ Hates it when one food touches another on the plate.

☐ Loves Carbs ☐ Loves Fruit ☐ Loves Veggies

Exercise Level: ☐ Non-existent ☐ Minimal ☐ Moderate ☐ Intense

Type of Exercise: ☐ Walking ☐ Running ☐ Biking ☐ Weight Training ☐ Sport, list all sports she/he participates in:

_____

How many hours of TV per day?_____ How many hours of computer time per day? _____

How many hours of gaming per day (X-Box, etc.)?_____

Other Health Concerns:

Check any of the conditions your child has suffered from in the past 6 months:

☐ Ear Infections ☐ Seizures ☐ Cold/Flu ☐ Asthma ☐ Allergies ☐ Digestive Problems

☐ Colic ☐ ADD/ADHD ☐ Bed Wetting ☐ Recurring Fevers

Others: _____

_____

Medical History:

Has your child benefited from previous Chiropractic care? ☐ Yes ☐ No When was he/she last adjusted? _____

Does your child ever “crack” or “pop” his/her own neck? ☐ Yes ☐ No or back? ☐ Yes ☐ No

Why?_____

Date of your child’s last physical exam? _____ Blood work? _____ Urine test? _____

Please list and date any hospitalizations, surgeries, traumas and serious infections:

1. _____ 3. _____

2. _____ 4. _____

Chiropractic Neurology & Wellness Center

Please check if your child is currently experiencing any of these issues, or has experienced any of them in the past year.

General/Constitutional:

	Current	Past Year		Current	Past Year		Current	Past Year		Current	Past Year
Dizziness	☐	☐	Lightheaded	☐	☐	Headache	☐	☐	Unsteady	☐	☐
Fatigue	☐	☐	Fever/Chills	☐	☐	Night Sweats	☐	☐	Anemia	☐	☐
Bleeding	☐	☐	Diabetes	☐	☐	Thyroid	☐	☐	Fainting	☐	☐
Weight Gain	☐	☐	Weight Loss	☐	☐	Cancer	☐	☐	Insomnia	☐	☐

Other: _____

Musculoskeletal:

	Current	Past Year		Current	Past Year		Current	Past Year		Current	Past Year
Stiffness	☐	☐	Pain	☐	☐	Swelling	☐	☐	Scoliosis	☐	☐
Arthritis	☐	☐	Weakness	☐	☐	Twitching	☐	☐	Tremors	☐	☐
Numbness	☐	☐	Other: _____								

Gastrointestinal:

	Current	Past Year		Current	Past Year		Current	Past Year		Current	Past Year
Belching/Gas	☐	☐	Heartburn	☐	☐	Ulcers	☐	☐	Vomiting	☐	☐
Hernia	☐	☐	Constipation	☐	☐	Diarrhea	☐	☐	Nausea	☐	☐
Bloody Stools	☐	☐	Abdominal Pain	☐	☐	Liver	☐	☐			

Other: _____

Skin:

	Current	Past Year		Current	Past Year		Current	Past Year		Current	Past Year
Rashes	☐	☐	Mole Changes	☐	☐	Itching	☐	☐	Redness	☐	☐
Nail Changes	☐	☐	Other: _____								

Respiratory:

	Current	Past Year		Current	Past Year		Current	Past Year		Current	Past Year
Breathing	☐	☐	Spitting phlegm	☐	☐	Spitting blood	☐	☐	Allergies	☐	☐
Asthma	☐	☐	Chronic Cough	☐	☐	Pneumonia	☐	☐	Short Breath	☐	☐

Other: _____

Eye, Ears, Nose, Throat:

	Current	Past Year		Current	Past Year		Current	Past Year		Current	Past Year
Blurry Vision	☐	☐	Double Vision	☐	☐	Eye Pain	☐	☐	Glaucoma	☐	☐
Hearing Loss	☐	☐	Ringing in Ears	☐	☐	Ear Infections	☐	☐	Sinus issue	☐	☐
Nose Bleeds	☐	☐	Ear Pain	☐	☐	Sore Throat	☐	☐	Hoarseness	☐	☐
Jaw Pain	☐	☐	Speech Issues	☐	☐						

Other: _____

Cardiovascular:

	Current	Past Year		Current	Past Year		Current	Past Year
Racing Heart	☐	☐	Chest Pain	☐	☐	Pacemaker	☐	☐
High Cholesterol	☐	☐	High Blood Pressure	☐	☐	Swollen Feet/Legs/Hands	☐	☐
Heart Problems	☐	☐	Irregular Heartbeat	☐	☐			

Other: _____

Genitourinary:

	Current	Past Year		Current	Past Year		Current	Past Year
Urination	☐	☐	Frequent Urination	☐	☐	Painful Urination	☐	☐
Incontinence	☐	☐	Dribbling	☐	☐	Blood in Urine	☐	☐
Kidney Disease	☐	☐	Bladder Disease	☐	☐			

Other: _____

Neurologic/Psychiatric:

	Current	Past Year		Current	Past Year		Current	Past Year		Current	Past Year
Dizziness	☐	☐	Convulsions	☐	☐	Tremors	☐	☐	Paralysis	☐	☐
Depression	☐	☐	Anxiety	☐	☐	Memory Loss	☐	☐	Confusion	☐	☐
Phobias	☐	☐	Addiction	☐	☐	Mania	☐	☐	Facial Tics	☐	☐
Body Tics	☐	☐	Other: _____								

Please list any food sensitivities or food allergies your child has: _____

_____

List your child's 4 healthiest foods eaten regularly:

1. _____ 3. _____

2. _____ 4. _____

List your child's 4 unhealthiest foods eaten regularly:

1. _____ 3. _____

2. _____ 4. _____

How many times per week does your child eat candy? _____

How many times per week does your child drink soda pop? _____

List the top 4 foods your child craves regularly:

1. _____ 3. _____

2. _____ 4. _____

Do you find it difficult as a parent to have your child on a special diet? ☐ Yes ☐ No

Please check 0-3 with "0" meaning not at all, and "3" meaning often.	0	1	2	3
Section A:				
Does your child eat pasta, breads, and breaded foods?	☐	☐	☐	☐
Does your child experience fatigue, hyperactivity, etc. after eating foods containing wheat/gluten?	☐	☐	☐	☐
Does your child consume dairy products?	☐	☐	☐	☐
Does your child experience fatigue, hyperactivity, etc. after consuming dairy products?	☐	☐	☐	☐
Section B:				
Does your child eat fried foods?	☐	☐	☐	☐
Does your child eat roasted nuts or seeds?	☐	☐	☐	☐
Is your child missing essential fatty acid-rich foods in his/her diet? (i.e., avocados, flax seeds, olives)	☐	☐	☐	☐
Section C:				
Is your child's mental speed slow?	☐	☐	☐	☐
Does your child have difficulty with learning or memory?	☐	☐	☐	☐
Does your child have difficulty with balance and coordination?	☐	☐	☐	☐
Section D:				
Does your child have stress?	☐	☐	☐	☐
Does your child not have enough sleep and rest?	☐	☐	☐	☐
Does your child not have regular exercise?	☐	☐	☐	☐
Does your child feel overly worried and scared?	☐	☐	☐	☐
Section E:				
Does your child have temper tantrums?	☐	☐	☐	☐
Does your child exhibit wild behavior?	☐	☐	☐	☐
Does your child frequently yell or scream for unnecessary reasons?	☐	☐	☐	☐
Does your child have an inability to nap or sleep when physically exhausted?	☐	☐	☐	☐
Is your child overly talkative?	☐	☐	☐	☐
Does your child fidget and squirm when seated?	☐	☐	☐	☐
Does your child run and climb excessively when it is inappropriate?	☐	☐	☐	☐
Does your child have difficulty playing quietly or engaging in leisure activities?	☐	☐	☐	☐
Section F:				
Does your child have anxiousness and panic for minor reasons?	☐	☐	☐	☐
Does your child feel overwhelmed for minor reasons?	☐	☐	☐	☐
Does your child find it difficult to relax when he/she is awake?	☐	☐	☐	☐
Does your child have disorganized attention?	☐	☐	☐	☐
Section G:				
Does your child seem depressed?	☐	☐	☐	☐
Does your child have mood changes with overcast weather?	☐	☐	☐	☐
Does your child have symptoms of inner rage?	☐	☐	☐	☐
Does your child seem uninterested in games or hobbies?	☐	☐	☐	☐
Does your child have difficulty falling into deep restful sleep?	☐	☐	☐	☐
Does your child seem uninterested in friendships?	☐	☐	☐	☐
Does your child have symptoms of unprovoked anger?	☐	☐	☐	☐
Does your child seem uninterested in eating?	☐	☐	☐	☐

Please check 0-3 with “0” meaning not at all, and “3” meaning often.	0	1	2	3
Section H:				
Does your child have difficulty handling stress?	☐	☐	☐	☐
Does your child have anger and aggressions while being challenged?	☐	☐	☐	☐
Does your child feel tired even after long sleeps?	☐	☐	☐	☐
Does your child tend to isolate from others?	☐	☐	☐	☐
Does your child get distracted easily?	☐	☐	☐	☐
Does your child have constant need and desire for candy and sugar?	☐	☐	☐	☐
Section I:				
Does your child have difficulty with visual memory?	☐	☐	☐	☐
Does your child have difficulty remembering locations?	☐	☐	☐	☐
Does your child have fatigue or low endurance for learning activities?	☐	☐	☐	☐
Does your child have difficulty with attention or low attention span or endurance?	☐	☐	☐	☐
Does your child have slow or difficult speech?	☐	☐	☐	☐
Does your child have uncoordinated or slow movement?	☐	☐	☐	☐

Chiropractic Neurology & Wellness Center

Family Medical History

Check all that apply	Mother	Father	Brother	Sister	Children	Mother's Parents	Father's Parents	Aunts & Uncles
Ages						NA	NA	NA
Cancers	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐	☐
Obesity	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐
Rheumatoid Arthritis	☐	☐	☐	☐	☐	☐	☐	☐
Psoriatic Arthritis	☐	☐	☐	☐	☐	☐	☐	☐
Celiac Disease	☐	☐	☐	☐	☐	☐	☐	☐
Hoshimoto's Disease	☐	☐	☐	☐	☐	☐	☐	☐
Hypothyroidism	☐	☐	☐	☐	☐	☐	☐	☐
Multiple Sclerosis	☐	☐	☐	☐	☐	☐	☐	☐
Lupus (SLE)	☐	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐	☐
Food Allergies	☐	☐	☐	☐	☐	☐	☐	☐
Environmental Allergies	☐	☐	☐	☐	☐	☐	☐	☐
Psoriasis/Eczema	☐	☐	☐	☐	☐	☐	☐	☐
Parkinson's Disease	☐	☐	☐	☐	☐	☐	☐	☐
ALS	☐	☐	☐	☐	☐	☐	☐	☐
Dementia	☐	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐	☐
Bipolar Disease	☐	☐	☐	☐	☐	☐	☐	☐
ADD/ADHD	☐	☐	☐	☐	☐	☐	☐	☐
Autism	☐	☐	☐	☐	☐	☐	☐	☐
Substance Abuse	☐	☐	☐	☐	☐	☐	☐	☐
Genetic Disorders	☐	☐	☐	☐	☐	☐	☐	☐
Scoliosis	☐	☐	☐	☐	☐	☐	☐	☐
Other								
Other								

Patient Health Information

We want you to know how your Patient Health Information (PHI) will be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your PHI we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow Chiropractic Neurology & Wellness Center (CNWC) to use their patient Health Information (PHI) for the purpose of treatment, payment, health care operations, and coordination of care.

2. The patient has the right to examine and obtain a copy of his/her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.

3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.

4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.

5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by CNWB to assure that your records are not readily available to those who do not need them.

6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.

7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Patient's Name:_____
PLEASE PRINT

_____ _____
Signature of Parent or Legal Guardian Date

_____ _____
Witness Date

Consent to Treatment of a Minor

I (We) being the parent or guardian of _____ a minor, the age of _____ do hereby consent, authorize and request Doctor _____ to administer such treatment deemed advisable, necessary or requested on the minor listed above.

I (We) agree to hold Doctor _____ free and harmless from any claims, suits for damages or complications which may result from such treatment.

_____ _____

Signature of Parent or Legal Guardian Date

_____ _____

Witness Date

A holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable.