



**PEDIATRIC INTAKE FORM**

Thank you for taking time to fill out the following forms. Our mission is to support people in their journey to optimum health, function, and well-being. Our focus will be to help bring your system into a state of balance/ease, to assist you as you become more aware, stronger, and empowered in your health, & to create supports for you to better adapt to stress and activities of daily living.

Step one in our time together is learning more about you – the whole person. We understand that health expression is multi-faceted (physical, chemical, emotional/mental). Reviewing each aspect and the stressors in each category help us paint the whole picture and decide where to go from here.

We are honored to have you here. Our team will take amazing care of you & your family!

**BASICS**

Legal Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Nickname/Preferred Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender: ☐ Male ☐ Female

Phone: (h) \_\_\_\_\_ (c) \_\_\_\_\_ (w) \_\_\_\_\_

Email: \_\_\_\_\_

Preferred Method of Contact: ☐ Call – Home, Cell, or Work ☐ Text ☐ Email

Legal Guardian Name(s): \_\_\_\_\_

Who can we thank for referring you? \_\_\_\_\_

**EMERGENCY CONTACT**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home: \_\_\_\_\_ Mobile: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Office Number: \_\_\_\_\_

**WHAT BRINGS YOU HERE?**

People seek Chiropractic/Acupuncture care for a variety of reasons depending on personal needs, expectations, perceptions, and past experiences. We want to do our best to understand so that our team can meet your specific needs. Please check those that apply to you:

**RELIEF CARE**

- |  |   |
|--|---|
| <input type="checkbox"/> Pain reduction    | <input type="checkbox"/> Symptom relief   |
| <input type="checkbox"/> Crisis Management | <input type="checkbox"/> Stress reduction |

**CORRECTIVE CARE**

- |  |   |
|--|---|
| <input type="checkbox"/> Improved function | <input type="checkbox"/> Increased strength   |
| <input type="checkbox"/> Improved movement | <input type="checkbox"/> Improved performance |

**HOLISTIC CARE**

- |  |                                     |
|--|-------------------------------------|
| <input type="checkbox"/> Improved quality of life        | <input type="checkbox"/> Prevention |
| <input type="checkbox"/> Improved immune system function |                                     |
| <input type="checkbox"/> Optimum nervous system function |                                     |
| <input type="checkbox"/> Full body integration           | <input type="checkbox"/> Longevity  |

**OTHER**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Office Rep. Initial: \_\_\_\_\_





## MAJOR FOCUS / COMPLAINT / CHALLENGE

#1 Health Goal: \_\_\_\_\_

#1 Health Challenge: \_\_\_\_\_

Please tell us why you are here:

\_\_\_\_\_  
\_\_\_\_\_

When did it start? \_\_\_\_\_

What happened? \_\_\_\_\_

What daily activity(ies) is this affecting? \_\_\_\_\_

Since onset, is this condition: ☐ Improving ☐ Worse ☐ Same

Improves with:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Worsens with:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## PREVIOUS TREATMENT / TESTING

- |   |  |
|---|--|
| <input type="checkbox"/> None                     | <input type="checkbox"/> Massage _____ |
| <input type="checkbox"/> Chiropractor _____       | <input type="checkbox"/> X-rays _____  |
| <input type="checkbox"/> Medical Doctor _____     | <input type="checkbox"/> MRI _____     |
| <input type="checkbox"/> Physical Therapist _____ | <input type="checkbox"/> CT _____      |
| <input type="checkbox"/> Acupuncturist _____      | <input type="checkbox"/> Other: _____  |
| <input type="checkbox"/> ER/Urgent Care _____     | <input type="checkbox"/> None          |
| <input type="checkbox"/> Orthopedic _____         |  |

## HISTORY / LIFESTYLE / STRESSORS

### Pregnancy History

Illnesses/Complications: \_\_\_\_\_

Medications During Pregnancy: \_\_\_\_\_

High Emotional Stress During Pregnancy? ☐ Yes ☐ No

### Birth History

Labor @ \_\_\_\_\_ weeks Induced: ☐ Yes ☐ No Pitocin: ☐ Yes ☐ No

Location: ☐ Home ☐ Hospital ☐ Birth Center Interventions: ☐ Forceps ☐ Vacuum ☐ Caesarian

Birth Complications: \_\_\_\_\_ Birth Weight: \_\_\_\_\_

Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Office Rep. Initial: \_\_\_\_\_





### Nutrition

Breastfed: ☐ Yes ☐ No

How Long? \_\_\_\_\_

Formula: ☐ Yes ☐ No

Type: \_\_\_\_\_

Food allergies/intolerances? \_\_\_\_\_

Does your child eat well? ☐ Yes ☐ No

Healthy Digestion? \_\_\_\_\_

### Emotional/Developmental Health

Does your child sleep well? ☐ Yes ☐ No

If no, please explain: \_\_\_\_\_

Is your child hitting typical age-appropriate milestones? ☐ Yes ☐ No

Is your child happy/content overall? ☐ Yes ☐ No

### Physical Stress

Any significant traumas, falls, or injuries? ☐ Yes ☐ No ☐ Unsure

If yes, when and please explain important details: \_\_\_\_\_

Any hospital visits? ☐ Yes ☐ No

Have you had any surgeries, fractures or dislocations? ☐ Yes ☐ No

If yes, when and please explain important details: \_\_\_\_\_

Any major motor vehicle accidents? ☐ Yes ☐ No

If yes, when and please explain important details: \_\_\_\_\_

Are you in prolonged postures, repetitive motions, or strenuous physical stressors? ☐ Yes ☐ No ☐ Unsure

If yes, please describe: \_\_\_\_\_

Hobbies/Sports: \_\_\_\_\_

### Chemical Stress

Prescription or over-the-counter medications? ☐ Yes ☐ No

If yes, please list what and why: \_\_\_\_\_

Supplements or vitamins? ☐ Yes ☐ No

If yes, please list what and why: \_\_\_\_\_

Water Intake: ☐ Well-hydrated ☐ Dehydrated

Do you eat well? (*well-balanced, nutrient-rich, fresh, organic*)

☐ Yes, always ☐ Mostly clean, work in progress ☐ Never, my diet needs to be addressed

Regular exposure to pollutants, strong odors, chemicals, or aerosols?

☐ Daily ☐ Occasional ☐ Former ☐ Never

Has your child been vaccinated? ☐ Yes ☐ No

Vaccine Plans: ☐ None ☐ Delayed Schedule ☐ Full Schedule

Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Office Rep. Initial: \_\_\_\_\_



