Today's Date:

PEDIATRIC INTAKE FORM
Infant – 10 years old

PATIENT INFORMATION

Child's Name:_____ Parent/Guardian Name:_____
Gender: ☐ Male ☐ Female D.O.B:_____/_____/_____ Age_____
Current Height:_____ Current Weight:_____
Address: _____
City, State, Zip: _____

Other Children's names/ages:
_____

Email: _____ Home Phone: _____
Cell Phone: _____ Cell Provider:_____ ☐Yes! I want to opt for text appt reminders
How did you hear about us? _____
Has your child been adjusted by a chiropractor before? ☐ YES ☐ NO
If yes, reason for those visits: _____
When was the last visit?_____

Is your child receiving care from other health professionals? ☐ YES ☐ NO
If yes, list name and specialty: _____
Who is your family's primary care physician?_____
Contact information:_____

HEALTH HISTORY
Describe the health concern that prompted this visit:_____
When did this concern begin? _____ How did this concern begin? _____

Has this condition: ☐ Worsened ☐ Stayed the same ☐ Been Intermittent
Does this interfere with: ☐ School ☐ Sleep ☐ Daily Routine
What makes this condition worse? _____
What makes this condition better? _____
Has your child seen anyone else for this concern? ☐ YES ☐ NO Type of treatment:_____
Please list any medications taken for this concern:_____

Child's birth was at: ☐ Home ☐ Birthing Center ☐ Hospital OB/Midwife/Physician was:_____
Child birth was: ☐ Natural vaginal with no medications
☐ Vaginal with interventions: ☐ Pitocin ☐Epidural ☐ Pain Medications ☐ Vacuum Extraction
☐ Forceps ☐ IV antibiotics ☐Other:_____

C-Section: ☐ Scheduled ☐ Emergency
☐ Adopted ☐ Prenatal history unknown ☐ Birth history unknown
Was your child at any time during your pregnancy in a constrained position?: ☐ YES ☐ NO ☐ UNSURE
If yes, please describe: ☐ Breech ☐ Transverse ☐ Face/Brow presentation
Complications during pregnancy: ☐YES ☐ NO (If yes, describe)_____

Medications during pregnancy: ☐ YES ☐ NO
(If yes, describe)_____
If so, which ones and how often? (include Over-the-counter):_____
_____

Exposure to drugs, alcohol, cigarettes, or second hand smoke during pregnancy: ☐ YES ☐ NO
(If yes, describe)_____

Birth Weight:_____lbs _____oz Birth Height:_____
Please list all of your child's hospitalizations and surgical history (include year):

_____

_____

Please list any major injuries, accidents, falls and/or fractures your child has sustained in his/her lifetime:

_____

The human body is designed to be healthy. The primary system in the body, which coordinates health and function, is the nervous system. Your nervous system is surrounded and protected by the bones of the spine, called vertebrae. Many of the common health challenges that adults experience have their origins during the developmental years, starting at birth. Layers of damage to the spine and nervous system occur as a result of various traumas, toxins, and emotional stress. The result may be misalignment to the spinal column and damage to the nervous system – a condition called Vertebral Subluxation. Please answer the following questions to give us a better understanding about your child's state of wellness and factors which may be contributing to vertebral subluxation and impeding your child's ability to heal.

What signals has your child's body been communicating?

PAST	PRESENT		PAST	PRESENT		PAST	PRESENT	
☐	☐	Asthma	☐	☐	Frequent Diarrhea	☐	☐	Slow Weight Gain
☐	☐	Respiratory Tract Infections	☐	☐	Constipation	☐	☐	Asymmetrical Crawling
☐	☐	Sinus Problems	☐	☐	Flatulence	☐	☐	Asymmetrical Gait
☐	☐	Ear Infections	☐	☐	Headaches/Migraines	☐	☐	Weight Challenges
☐	☐	Tonsillitis	☐	☐	Neck Pain	☐	☐	Bed Wetting
☐	☐	Strep Throat	☐	☐	Torticollis/Head Tilt	☐	☐	Sleeping Problems
☐	☐	Frequent Colds/Croup	☐	☐	Trouble Nursing	☐	☐	Night Terrors
☐	☐	Recurrent Fevers	☐	☐	Back Pain	☐	☐	Tip Toe Walking
☐	☐	Eczema	☐	☐	Growing Pains	☐	☐	Seizures
☐	☐	Rashes	☐	☐	Scoliosis	☐	☐	Tremors/Shaking
☐	☐	Allergies	☐	☐	Red, Swollen, Painful Joints	☐	☐	ADD/ADHD
☐	☐	Food Sensitivities	☐	☐	Colic	☐	☐	Autism
☐	☐	Digestive Issues	☐	☐	Frequent Crying Spells/Colic			

Other:_____

What is your primary goal for your child at our clinic?_____
_____

Our goal is to provide a detailed assessment of your child's current health status and provide you with the resources for a highly engaged and healthy child whose body is functioning at its absolute peak potential while they grow. Essential to this healthy growth is a properly functioning nervous system that is able to function free from interference called subluxation.

No-Call/No-Show Policy

Due to several No-Call/No-Show appointments and out of courtesy for other practice members who may need a certain time slot, we have found it necessary to implement a No-Call/No-Show Policy and fee.

We ask that you please understand the reason behind this policy is that time is valuable to everyone: you, other patients, doctors and assistants.

No-Call/No-Show Policy

We understand that life happens and schedules change, however we do ask that if you are unable to make your appointment, please call or text us when you receive your appointment reminder (within two hours) to cancel and reschedule. 24 HOURS NOTICE IS IDEAL. If you miss your appointment and did not call ahead to inform us, you will be charged a $25 NO-CALL/NO-SHOW Missed Appointment Fee that will be assessed to your card on file.

First Offense- No charge, graceful warning

Second (+) offense- $25

Running Late

We pride ourselves on doing our best to still get you adjusted when you are running late to your scheduled appointment, however we ask that you please let us know by call or text if you will be more than 10 minutes late. Please know that if you are running more than 10 minutes late, you have run into the next time slot and may have to wait for the members scheduled during that time to get adjusted before you see the doctor.

We thank you for your understanding and consideration as we are a growing office and want to continue to serve everyone to the best of our ability.

Yours in Health and Healing,

Vitality Family Chiropractic

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No-Call/No-Show Policy

Please Read Completely

I,_____ will make every effort to give at least two hours advance notice if I need to cancel and reschedule my appointment. I understand that 24-hour notice is ideal and will do my best to let the front desk know as soon as possible that I will be late or needing to reschedule my appointment. I agree, permit and authorize Vitality Family Chiropractic the right to charge my credit card $25 if I do not call or show to my scheduled appointment.

I have read fully, understand and agree to the above.

_____ _____

Patient Signature Date