Mason Family Chiropractic & Wellness

Pediatric Chiropractic Intake Form

Patient (Child) Information:
Name: _____ Date: _____

Address: _____
Sex: Male Female Date of Birth: _____ Height: _____ Weight: _____
Patient SSN: _____ Name of Parents/Guardian: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Email: _____ Would you like our newsletter emailed to you: Y N
Whom may we thank for referring you? _____
Authorized Representative/Parent/Guardian: _____ Phone: _____

Present Complaint: _____
When did this begin? _____ Was there an accident or injury involved? Y N
Has your child had any past treatment for this complaint? Y N Describe: _____
Current medications: _____

General Questions/Prenatal History:
Any complications during pregnancy? Y N Explain: _____
Medications taken during pregnancy: _____ Cigarettes or alcohol during pregnancy: Y N
Birth Intervention: Forceps Vacuum C-Section
Complications during delivery? Y N Explain: _____
Genetic disorders or disabilities: _____
_____
How many times has your child been prescribed antibiotics in the past 6 months? _____ Total during lifetime: _____
Has your child received vaccinations? Y N

Feeding History:
Breast Fed: Y N How long: _____
Formula Fed: Y N How long: _____

Introduced to: Solids at _____ Months
Cows milk at _____ Months
Food Allergies or Intolerances: Y N
List: _____

Childhood Diseases:
Chicken Pox: Y N Age: _____
Rubella: Y N Age: _____

Rubeola: Y N Age: _____
Mumps: Y N Age: _____
Whooping Cough: Y N Age: _____
Other: _____ Age: _____

Developmental History:
During the following times your child's spine is the most vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference). At what age was your child able to:

_____ Respond to Sound
_____ Respond to Visual Stimuli
_____ Hold Head Up Alone
_____ Sit Up Alone
_____ Cross Crawl
_____ Stand Alone
_____ Walk Alone

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (ie: a bed, changing table, down stairs, etc). Was this the case with your child? Y N
Explain: _____
Is/has your child been involved in any high impact or contact type of sports (ie: soccer, football, gymnastics,) Y N

Has your child ever been involved in a car accident? Y N Explain:_____
Other traumas not described above? Y N Explain:_____
Prior surgeries? Y N Explain:_____

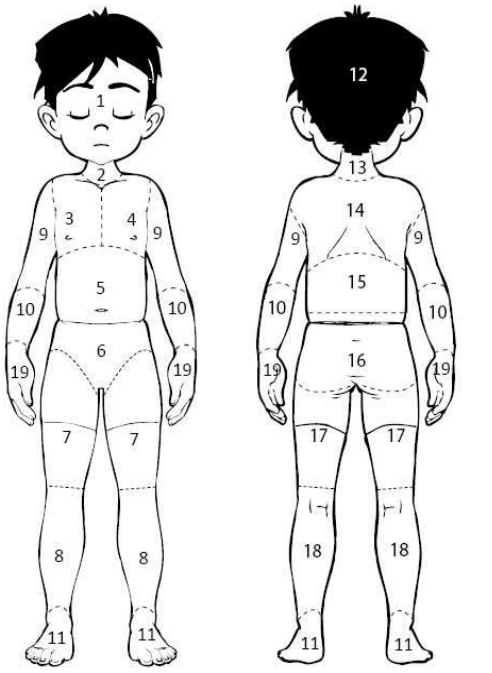
Review of Systems

Please check if your child has had any of the following:

____Headaches	____Postural Imbalances	____Growing Pains	____Scoliosis	____Tonsillits
____Asthma	____Torticollis	____Ear Infections	____Seizures	____Sleep Problems
____Digestive Problems	____Bedwetting	____PDD/Autism	____ADD/ADHD	____Frequent Fever
____Colic	____Learning Difficulties	____Acid Reflux	____Hip Dysplasia	____Allergies

How would you rate your child's diet?_____Well Balanced_____Average_____High sugar/processed foods
Does your child consume artificial sweeteners? Y N
Number of hours your child sleeps:_____hours per night_____hours per day/naps
Sleep Quality:____Good_____Fair_____Poor

Imagine this picture is your body. Can you color the area that is hurting you right now?



1 - FACE
2 - NECK
3 - LEFT CHEST
4 - RIGHT CHEST
5 - STOMACH
6 - ABDOMEN
7 - THIGHS
8 - LEGS
9 - UPPER ARMS
10 - LOWER ARMS
11 - FEET
12 - BACK OF HEAD
13 - BACK OF NECK
14 - UPPER BACK
15 - MIDDLE BACK
16 - LOWER BACK
17 - BACK THIGHS
18 - BACK LEGS
19 - HANDS

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Authorization to Treat a Minor

I,_____ the undersigning parent/guardian having legal custody/guardianship of _____, a minor, do hereby authorize, request and direct Dr.Mason/Hopkins and whomever she/he might designate as assistant to perform in judgment any examination and chiropractic diagnosis or treatment which is deemed necessary.

Any specific written authorization you provide may be revoked at any time by writing to us at the address provided on the front of this form.

Patient:_____ Signature: _____
Print Name Parent/Legal Guardian