Whelan Chiropractic Pediatric Intake Form

Patient Name_____ SS#_____
Name of Parents / Guardians_____
Address _____City _____State _____Zip_____
Home Phone_____ Work Phone_____ Email Address_____
Birth Date _____ Sex_____ Weight_____ Height_____ Number of siblings_____
Who can we thank for referring you to us? _____
Reason for seeking chiropractic care**:**_____
Other Doctors seen for this condition Y/N Specialty: _____
Prior treatment and outcome: _____
Other Health Problems: _____

Symptoms: Please check any current or past problems your child has on the list below:

☐Dizziness	☐Allergies	☐Diarrhea	☐Broken bones
☐ADHD	☐Runny Nose	☐Poor Appetite	☐Sprains/Strains
☐Backaches	☐Itchy Eyes	☐Hyperactivity	☐Hernias
☐Heart Condition	☐Rashes	☐Behavioral	☐Neck Pain
☐Chronic Earaches	☐Unusual Moles	☐Poor Memory	☐Arm/Elbow Pain
☐Diabetes	☐Neuritis	☐Insomnia	☐Leg/Hip Pain
☐Tuberculosis	☐Digestive	☐Nightmares	☐Knee/Foot Pain
☐Hypertension	☐Sinus Trouble	☐Bed Wetting	☐Growing pains
☐Fever/Chills	☐Cough/Wheeze	☐Pain Urinating	☐Joint Pain
☐Frequent Colds	☐Chest Pain	☐Convulsions _Paralysis	☐Scoliosis
☐Arthritis	☐Constipation	☐Muscle Pain	☐Blood disorders
☐Headaches	☐Anemia	☐Fainting	☐Stomach Aches _Other
☐Asthma	☐Rheumatic Fever	☐	☐

Health History:
Name of Pediatrician: _____ Date of last visit _____
Reason for visit: _____
Medications and conditions being treated: _____
Has your child ever taken antibiotics? Y/N Condition treated: _____
Has your child been injured participating in contact sports (Soccer, Football, Martial Arts…) Y/N
If yes, describe (Sprain, Broken Bone, Head Trauma…) _____
Has your child ever been involved in a car accident? Y/N Date & Injuries _____
Has your child ever fallen head first from (Changing Table, Bed, Stairs…) Y/N _____
Other traumas not described above? Y/N Type & Date: _____
Prior surgery: Y/N Type and Date:_____ Menarche: Y/N Age:_____

Prenatal History
Location of Birth: ☐ Home ☐ Birthing Center ☐ Hospital ☐ Stepchild ☐ Adopted
Complications during pregnancy: Y/N List: _____
Ultrasounds during pregnancy: N Y Number: _____
Medications during pregnancy/delivery: Y/N List: _____
Cigarette / Alcohol use during pregnancy: Y/N
Birth intervention: ☐ Forceps ☐ Vacuum ☐ Caesarian, Why?_____
Complications during delivery: Y/N List: _____
Genetic disorders or disabilities: Y/N List: _____
Birth weight_____ Birth length_____ APGAR scores: 1 min _____ 5 min _____

Feeding history
Breast Fed: Y/N How long'?_____ Formula fed: Y/N How long'?_____
Type:_____ Introduced to solids at _____ months. Cow's milk at _____ months
Food / juice allergies or intolerances Y/N List: _____

Developmental History
Sleep (Hrs per night) _____ Naps (number & lengths) _____ Problems sleeping _____
At what age was your child able to: Crawl _____ Sit alone _____ Stand alone _____ Walk alone _____ Say words _____

Childhood Diseases
☐ Chicken Pox - Age _____ ☐ Mumps - Age _____ ☐ Rubella - Age _____ ☐ Whooping cough - Age _____
☐ Measles - Age _____ ☐ Meningitis - Age _____ ☐ Tuberculosis - Age _____ ☐ Other - Age _____

Vaccination History:
☐ HBV / Hep B (Hepatitis B) – Age _____ ☐ MMR (Measles, Mumps, Rubella) – Age _____
☐ DTP or ☐ DTaP (Diphtheria, Tetanus, Pertussis) – Age _____ ☐ Varicella (Chicken Pox) – Age _____
☐ HbCV / Hib (H. influenzae type b conjugate) – Age _____ ☐ PCV (Pneumoccocal) – Age _____
☐ OPV (Oral Polio Vaccine) or ☐ IPV (Inactivated Poliovirus) – Age _____
Adverse Reactions to Any Vaccine? Y/N List: _____

Insurance
Do you have medical insurance? Y/N Insurance Company Name _____
Policy/ ID Number _____ Group Number _____
Insurance Company Phone number _____
Insured's Name _____Relationship to patient _____
Insured's DOB _____Insured's SS# _____
Insured's Employer _____ Insured's Employee Address_____

CONSENT TO CHIROPRACTIC CARE

I certify that the information that I have supplied is correct and accurate to the best of my knowledge.
I, _____, being the parent or legal guardian of _____ hereby grant permission for my child to receive chiropractic care.

Signed _____Witnessed _____

Date _____