# Delmar Chiropractic Office Pediatric Intake Form

Pediatric Intake Form (Birth to 12 years)

Childs Name_____ Today's Date ___/___/___
Date of Birth ___/___/___ Age: _____
Birth Height: _____ Birth Weight: _____ Current Height: _____ Current Weight: _____
Address_____
City _____ State _____ Zip _____
Mother's Name: _____ DOB ___/___/___ Mother's Cell: _____
Father's Name: _____ DOB ___/___/___ Father's Cell: _____
Pediatrician/Family MD _____ City/State _____
Last Visit: ___/___/___ Reason for visit: _____
Who is responsible for payment for services?
_____

**CHILD'S CURRENT PROBLEM:**

Purpose of this visit: Wellness Check-up _____ Injury or Accident _____ Other _____
Other Please explain: _____
If your child is experiencing Pain/Discomfort please identify where and for how long:_____
_____
1. When did the problem first begin? Date ___/___/___ Unknown ___ Gradual___ Sudden___
2. Ever had this problem before? No___ Yes___ If yes, when? _____
3. Any bowel or bladder problems since this problem began?: If yes, describe:
_____
4. Have you seen any other doctors for this problem? No___ Yes___ If yes, who?
_____
5. How long ago? _____
6. What were the results of past treatment? _____
7. How is this problem NOW?: Rapidly Improving___ Improving Slowly___ About the Same___ Gradually Worsening___ On & Off___
8. Please list any medication taken for this problem: _____

**CHILD'S HEALTH HISTORY:**

9. Anything notable about your child's birth? (c-section, forceps, torticollis) _____
_____
10. Has your child ever sustained an injury playing organized sports? No___ Yes___
If yes; please explain: _____
_____
11. Has your child ever sustained an injury in an auto accident? No___ Yes___
If yes; please explain: _____
_____
12. Had any Surgeries? No___ Yes___
If yes; please explain: _____
_____

13. Taken antibiotics? (For what condition?) _____
14. Take medications? (Which and for what condition?)_____
_____
15. Take Vitamins? (Which ones?) _____
16. How would you rate your child's diet? Well balanced ___ Average ___ High sugar/processed ___
17. How many hours a night does your child sleep and what is the quality of sleep?
Hours ___ Good ___ Fair ___ Poor ___

HAS YOUR CHILD EVER SUFFERED FROM: Please check all that apply

| | | | |
|---|---|---|---|
| ☐ Headaches | ☐ Broken Bones | ☐ Digestive Disorders | ☐ Behavioral Issues |
| ☐ Dizziness | ☐ Neck Problems | ☐ Poor Appetite | ☐ ADD/ADHD |
| ☐ Fainting | ☐ Arm Problems | ☐ Stomach Aches | ☐ Ruptures/Hernia |
| ☐ Seizures/Convulsion | ☐ Leg Problems | ☐ Reflux | ☐ Muscle Pain |
| ☐ Heart Trouble | ☐ Joint Problems | ☐ Constipation | ☐ Growing Pains |
| ☐ Chronic Earaches | ☐ Backaches | ☐ Diarrhea | ☐ Asthma |
| ☐ Sinus Trouble | ☐ Poor Posture | ☐ Hypertension | ☐ Walking Trouble |
| ☐ Scoliosis | ☐ Anemia | ☐ Colds/Flu | ☐ Sleeping Problems |
| ☐ Bed Wetting | ☐ Colic | ☐ Allergies | ☐ Other-explain below |

Other:_____
_____
Is there anything else we should know about your child? _____
_____
_____

I, _____ the undersigned parent/guardian have legal custody/guardianship of _____, a minor, do hereby authorize, request and direct DCO, and whomever they may designate as assistant, to perform in judgment any examination, diagnosis and chiropractic treatment which is deemed necessary.

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

Patient: _____Parent/GuardianSignature: _____