CORNERSTONE
FAMILY CHIROPRACTIC

Pediatric Intake Form

Patient Information

Name_____Date_____

Address_____
City_____State_____Zip_____

Phone Number _____

Date of Birth_____ Age____Gender □M □F

In case of emergency, contact

Name_____

Relationship_____

Contact Number_____

Mother's Name _____

Mother's Occupation _____

Mother's Phone_____

Mother's Email _____

Father's Name _____

Father's Occupation _____

Father's Phone _____

Father's Email _____

Who may we thank for referring you? _____

How can we help your child?

□Wellness Checkup □Other _____

_____

If your child is already experiencing a symptom(s), please describe: _____

_____

_____

_____

_____

When did this symptom(s) appear? _____

Has your child been treated for this symptom(s) on an emergency basis? □Yes □No

Please describe: _____

_____

Pregnancy History

Did mother experience any complications during her pregnancy? (check all that apply)

□ Back / Other Pain □ Gestational Diabetes □ Pre/Eclampsia □ Strep B □ Nausea / Vomiting

□ Pre-Term □ Fatigue □ Swelling □ Other (please describe)_____

Previous Chiropractic Care

Was the mother under chiropractic care during pregnancy? □ Yes □ No Last adjustment? _____

Has child had previous chiropractic care? □ Yes □ No Last adjustment? _____

Birth History

Type of Birth (check all that apply)

□ Hospital □ Birth Center □ Home □ Normal/Vaginal □ Breech

□ Cesarean □ Scheduled/Induced □ Epidural □ Forceps □ Vacuum Extraction

Problems during labor / delivery

□ Antibiotics □ Congenital Anomalies □ Failure to Thrive □ Respiratory Distress □ Meconium

□ Jaundice □ Extended Hospitalization □ Other_____

Growth and Development

Infant Feeding: □ Breast □ Bottle □ Formula

Number of hours of sleep each night: _____ Quality of sleep: _____

Has your child ever taken antibiotics? □ Yes □ No Condition treated: _____

Has your child ever been hospitalized? □ Yes □ No Condition treated: _____

At what age did the child:

Respond to sound_____ Crawl_____ Hold head up_____

Stand_____ Sit unsupported_____ Walk unsupported_____

Is this condition interfering with: □ School □ Sleep □ Concentration □ Daily Routine □ Other _____

Childhood Diseases, Illnesses, & Vaccinations

Has your child ever suffered from (check all that apply)?:

□ ADD/ ADHD
□ Allergies
□ Insomnia
□ Arm Problems
□ Asthma
□ Back Aches
□ Bed Wetting
□ Behavioral Problems
□ Broken Bones
□ Chronic Ear Aches/ Infections
□ Colds/ Flus
□ Colic
□ Convulsions/ Seizures
□ Delayed Speech
□ Diabetes
□ Stomach Aches
□ Paralysis
□ Digestive Issues (constipation / diarrhea)
□ Dizziness
□ Fainting
□ Headaches
□ Heart Trouble
□ Hyperactivity
□ Dark circles under eyes
□ Paralysis
□ Scoliosis
□ Runny Nose
□ Joint Problems
□ Leg Problems
□ Neck Problems
□ Neuritis
□ Orthopedic Problems
□ Poor Appetite
□ Jaw/TMJ Problems
□ Ruptures/ hernias
□ Sinus Trouble
□ Rashes
□ Walking Problems
□ Head/Sports injuries
□ Motor Vehicle Accident
□ Broken Bones
□ Falls
□ Other _____

Have you vaccinated your child?

□ Yes □ No □ As Scheduled □ Delayed Schedule

Allergies, Medications, Surgeries (Past and Present)

ALLERGIES (list)	MEDICATIONS / SUPPLEMENTS (list)	SURGERIES (list)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Authorization of Care of Minor

The statements made on this form are accurate to the best of my knowledge. I hereby authorize this clinic and its doctor(s) to administer care as they so deem necessary to my son/daughter/ward.

_____ _____

SIGNATURE DATE