SCHUCK FAMILY CHIROPRACTIC

76 East 15th Street
Edmond, Oklahoma 73013

Pediatric Intake Form (Birth to 12 Years)

Date: _____

Child's name: _____ DOB:_____

Parent/Guardian's Name: _____

Phone #:_____

Address: _____

City_____ State_____ Zip _____

Referred by: _____

Email address: _____

Has your child been checked by a Doctor of Chiropractic? Yes: ___ No: _____

If yes, please provide the name of the office and doctor.

_____

Were x-rays taken? Yes: _____ No: _____

Who is your medical pediatrician?

_____

Prenatal History:

Is your child adopted? Yes: _____ No: _____

Did you have any complications and when?

_____

Did you smoke? Yes: _____ No: _____

Did you consume alcohol? Yes: _____ No : _____

Did you take medication? Yes: _____ No: _____

Reason for the medication:

_____

Did you have any complications and when?

_____

_____

_____

Birth History:

Did you have ultrasound during this pregnancy? Yes: _____ No:_____

What was the frequency? _____

Place of Birth: Home: _____ Birthing Center: _____ Hospital: _____

Provider: Midwife: _____ OB-Gyn: _____ other: _____

Type of Birth:

Vaginal: _____ C-Section: _____

Were pain Medications used?

Yes: _____ No: _____

Was labor induced? Yes: _____ No: _____

If yes, why? _____

What position did you deliver in?

Squatting: _____ On back: _____Other:_____

Birth Trauma?

Doctor Assisted: ____ Twisting and/or Pulling: _____

Vacuum Extraction: ____ Forceps: _____

Newborn trauma (medical procedures and tests)

APGAR score: birth ____/IO 5-minutes ____/IO _____ Unsure

Did your child have a misshaped skull / head? Yes: _____ _ No: _____

Were there purple markings on their face? Yes: _____ No: _____

Did you breast feed your child? Yes: _____ No: _____

Does your child prefer one breast over the other? Yes: _____ No: _____

If yes, which side (circle one) Right Left

Did your child have any ties? Yes ____ No____ if yes were they revised and where?

_____

Does your child have any known food allergies? Yes: _____ No: _____

If yes, please list: _____

_____

_____

Health and developmental history

Has your child been immunized? Yes: _____ No: _____

Any known reactions to immunizations? Yes: _____ No: _____

Has your child ever had any surgeries? Yes: _____ No: _____

If yes, please elaborate. _____

Has your child been on antibiotics? Yes: _____ No: _____

If yes, how often and what for?

_____

_____

_____

Is your child currently taking any medication? Yes: _____ No: _____

Is you child currently taking any vitamins? Yes: _____ No: _____

What concerns or issues is your child experiencing that you are seeking chiropractic care for?

_____

_____

How long have they been experiencing this?

_____

Has anything made it better? If yes what? _____

Does anything make it worse? _____

Has your child experienced any major injuries? Yes No

If yes what: _____

Have you noticed any of the following symptoms?

<u>Gastrointestinal</u>

Constipation ____

Diarrhea ____

Colic____

frequent spit up

or vomiting ____

discomfort during

Bowel movements ____

Bed wetting/potty

training regression ____

<u>Respiratory</u>

Asthma ____

persistent cough ____

Difficulty Breathing ____

<u>Neurological</u>

Tremors ____

seizures ____

headache____

ADD/ADHD ____

<u>Cardiovascular</u>

Heart defects ____

Any issues when born? Yes No

<u>Ear,Nose,Throat</u>

Frequent nose bleeds ____

ear infections ____

hearing loss ____

sinus issues/allergies ____

<u>Skin</u>

Rash ____

Eczema ____

Dry skin ____

Has your child met all milestones on time?

0-3 mo:
able to smile/follow objects with eyes ____
can turn head side to side ____
rolls side to back ____

3-6 mo:
can lift head and chest on tummy _____
brings feet to mouth _____
can sit w/pelvic support _____
rolls back to tummy _____

6-I2 mo:
rolls in both directions _____
(may) get into crawling position ____
can sit up by self ____

9-I2 mo:
cross crawl begins ___
sitting to tummy/tummy to sit ___
can stand for a few seconds on own ___
(may) play in high bear position ___

I2-I9 mo:
starts to walk ___
enjoys social play ___
can move freely in all positions ___
more balance and coordination ___

Informed Consent to Treat:

I hereby authorize Dr. Schuck/Dr. Hanks/Dr.Freeman to administer exams and chiropractic care as deemed necessary to _____ (print minor patient's name).

Printed name of Parent/Guardian: _____

Date: _____

Signature parent/guardian: _____

Treating Doctor's signature: _____