PEAK Chiropractic
Pediatric Intake

CHILD'S NAME: _____ MOTHER'S NAME: _____
LAST FIRST MIDDLE LAST FIRST MIDDLE

FATHER'S NAME: _____
LAST FIRST MIDDLE

ADDRESS: _____ CITY/TOWN: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ MOTHER'S WORK PHONE: _____ FATHER'S WORK PHONE: _____

BIRTH DATE: ____/____/____ AGE: ____ BIRTH WEIGHT: _____ CURRENT WEIGHT: _____

SEX: _____ NO. OF SIBLINGS: _____ BIRTH LENGTH: _____ CURRENT LENGTH: _____

TYPE OF BIRTH: NORMAL VAGINAL _____ FORCEPS _____ BREECH _____ CESAREAN _____

HOME: _____ BIRTHING CENTER: _____ HOSPITAL: _____

WAS THERE PRESENCE AT BIRTH OF: _____ JAUNDICE (YELLOW) _____ CYANOSIS (BLUE)

CONGENITAL ANOMALIES/DEFECTS: _____

PURPOSE OF THIS APPOINTMENT: _____

INFANT FEEDING: BREAST _____ BOTTLE _____ FORMULA: _____

NO. OF HOURS OF SLEEP PER NIGHT: _____ QUALITY OF SLEEP: GOOD _____ FAIR _____ POOR ____

OBSTETRICIAN/MIDWIFE: _____
NAME LOCATED AT

PEDIATRICIAN/FAMILY MD: _____
NAME LOCATED AT

DATE OF LAST VISIT TO MD: _____ PURPOSE: _____

IMMUNIZATION HISTORY: _____ NORMAL _____ DELAYED _____ NONE

HAS YOUR CHILD BEEN TREATED ON AN EMERGENCY BASIS?: _____

DESCRIBE: _____

AUTHORIZATION FOR CARE OF MINOR

I HEREBY AUTHORIZE PEAK Chiropractic AND IT'S DOCTOR(S) TO PROVIDE CARE AS THEY SO DEEM NECESSARY TO MY SON/DAUGHTER/WARD.

SIGNED: _____ WITNESSED: _____ DATE: _____

PEAK Chiropractic
Pediatric Intake

PEDIATRIC CASE HISTORY

PREGNANCY HISTORY: _____

DELIVERY/BIRTH HISTORY: _____

DEVELOPMENTAL HISTORY: AT WHAT AGE DID THE CHILD...

_____ RESPOND TO SOUND
_____ FOLLOW AN OBJECT WITH HIS/HER EYES
_____ HOLD HEAD UP
_____ SIT ALONE
_____ CRAWL
_____ STAND
_____ WALK ALONE

CHILDHOOD DISEASES:
_____ CHICKENPOX
_____ MUMPS
_____ MEASLES
_____ RUBELLA
_____ RUBEOLA
_____ WHOOPING COUGH

OTHER: _____

HAS THIS CHILD EVER SUFFERED FROM:

- ☐ Dizziness
- ☐ Diabetes
- ☐ Arthritis
- ☐ Neuritis
- ☐ Anemia
- ☐ Poor Appetite
- ☐ Bed Wetting
- ☐ Fainting
- ☐ Neck Problems
- ☐ Joint Problems
- ☐ Backaches
- ☐ Tuberculosis
- ☐ Headaches
- ☐ Digestive Disorders
- ☐ Rheumatic Fever
- ☐ Hyperactivity
- ☐ Convulsions
- ☐ Walking Problems
- ☐ Arm Problems
- ☐ Heart Trouble
- ☐ Hypertension
- ☐ Asthma
- ☐ Sinus Trouble
- ☐ Orthopedic Problems
- ☐ Sugar Concentration
- ☐ Paralysis
- ☐ Broken Bones
- ☐ Leg Problems
- ☐ Chronic Earaches
- ☐ Colds/Flu
- ☐ Allergies
- ☐ Constipation
- ☐ Diarrhea
- ☐ Behavioral Problems
- ☐ Muscle Jerking
- ☐ Ruptures/Hernias
- ☐ "Growing Pains"

PRESENT HISTORY: _____

SURGERY: _____

MEDICATIONS: _____

ACCIDENTS: _____

FAMILY HISTORY: _____