Raders Spinal Health Center
Pediatric Intake Form

Patient Information

Child's Name _____ **Parent(s)/Guardian(s) Name** _____

Address _____ **City** _____ **State** ____ **Zip** _____

Home Phone _____ **Cell Phone** _____ **Work Phone** _____

Email _____ **Contact Preference:** ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐Email

Birthdate _____ **Age** _____ **Has your child ever had chiropractic care before?** ☐ Yes ☐ No

*If yes, please tell us the doctor's name _____ Were you pleased with the care? ☐ Yes ☐ No

How did you hear about our office? _____

Is this appointment related to an auto accident? ☐ Yes ☐ No

Is your child receiving care from other health professionals? ☐ Yes ☐ No

*If yes, please name then and their specialty _____

Who is your family's primary care physician? _____

Please list any drugs or medications your child is taking _____

_____

Please list any vitamins/herbs/homeopathic/other your child is taking _____

_____

Please list any allergies your child has _____

_____

Current Health

What health condition brings your child to our office? _____

When did the symptoms first begin? _____

How did the problem start? ☐ Suddenly ☐ Gradually ☐ Post-Injury

Is the condition ☐ Getting Worse ☐ Improving ☐ Intermittent ☐ Constant ☐ Not Sure?

What makes the problem better? _____

What makes the problem worse? _____

Has your child ever has a similar condition? ☐ Yes ☐ No **Please Explain** _____

Has your child been treated for this problem before? ☐ Yes ☐ No **Please Explain** _____

Does your child eat well? ☐ Yes ☐ No **Does your child have regular bowel/bladder movements?** ☐ Yes ☐ No

Has your child ever been checked for vertebral subluxations? ☐ Yes ☐ No ☐ Not Sure?

Health History

Child's birth was ☐ At home ☐ At a birthing center ☐ At a hospital

My ob./midwife/family physical was _____

Childs Birth was ☐ Natural vaginal (no medications/interventions) ☐ Vaginal with interventions ☐ Induction ☐ Pain medication ☐ Epidural ☐ Episiotomy ☐ Vacuum extraction ☐ Forceps ☐ Other: _____

☐ C-Section ☐ Scheduled ☐ Emergency **Please List any interventions/complications** _____

_____

Child's birth weight _____ Child's birth height _____ Current Weight _____ Current height _____

APGAR score at birth _____ APGAR score after 5 minutes _____

Growth & Development

Was your child alert and responsive within 12 hours of delivery? ☐ Yes ☐ No

If no, please explain _____

At what age did the child: Respond to sound _____ **Follow an object** _____ **Hold head up** _____

Vocalize _____ **Sit Alone** _____ **Teethe** _____ **Crawl** _____ **Walk** _____

Patient/hospitalizations/surgical history (please list below all surgeries and hospitalizations- please include the year they occurred _____

Please list any major injuries, accidents, falls and/or fractures your child has sustained in his/her lifetime, including the year

_____

Is your child breastfed ☐ Yes ☐ No If yes, how long? _____ **Formula introduced at age** _____

What type? _____ **Began solid foods at age** _____

Please list any foods/juice intolerance _____

Did mother smoke during pregnancy? ☐ Yes ☐ No **Did mother drink alcohol during pregnancy?** ☐ Yes ☐ No

Any illness of mother during pregnancy? ☐ Yes ☐ No

If yes, please explain including treatment/medications/supplements_____

_____

Any exposures to ultrasound? ☐ Yes ☐ No If so, how many and what was the medical reason?

_____

List any supplements taken during pregnancy _____

Any pets at home? ☐ Yes ☐ No **Any Smokers at home?** ☐ Yes ☐ No

Has your child received any vaccinations? ☐ Yes ☐ No If yes, which ones and list any reactions: _____

_____ **Has your child received any antibiotics?** ☐ Yes ☐ No

If yes how many times and list reason _____ **Any difficulty with breastfeeding** ☐ Yes ☐ No

If yes, Please explain _____ **Any difficulty bonding?** ☐ Yes ☐ No

If yes, Please explain _____ **Any behavioral problems?** ☐ Yes ☐ No

Any night terrors, sleepwalking or difficulty sleeping? ☐ Yes ☐ No If yes, Please explain _____

Age child began daycare _____ **Average number of hours of TV per week** _____

Does your child seem normal for their age? ☐ Yes ☐ No If no, please explain: _____

Family History review

Check those involving immediate family M=Mother F= Father S= Siblings G= Grandparents

Cancer, Type _____ ☐M ☐F ☐S ☐G **Depression** ☐M ☐F ☐S ☐G **Diabetes** ☐M ☐F ☐S ☐G **Heart Disease** ☐M ☐F ☐S ☐G

Back Problems ☐M ☐F ☐S ☐G **Liver Disease** ☐M ☐F ☐S ☐G **High Blood Pressure** ☐M ☐F ☐S ☐G **Scoliosis** ☐M ☐F ☐S ☐G

High Cholesterol ☐M ☐F ☐S ☐G **Lung Problems** ☐M ☐F ☐S ☐G **Neck Problems** ☐M ☐F ☐S ☐G **Seizures** ☐M ☐F ☐S ☐G

Osteoporosis ☐M ☐F ☐S ☐G Osteoarthritis ☐M ☐F ☐S ☐G **Rheumatoid Arthritis** ☐M ☐F ☐S ☐G

Other:

Do you know about Chiropractic?

Do you know what a subluxation is? ☐ Yes ☐ No **Do any of your friends/relatives see a chiropractor?** ☐ Yes ☐ No

Are you seeking chiropractic for ☐ Health maintenance/optimization ☐ Health problems ☐ both

What would you like to gain from chiropractic care? _____ **Are there other health concerns or anything else you'd like us to know about your child?** _____