PEDIATRIC INTAKE & HISTORY

WOLFF FAMILY
CHIROPRACTIC

PATIENT INFORMATION

Patient Name ______________________
Address ______________________
City ______________ State ______
Home Phone ______________________
Cell Phone ______________________
Email ______________________
Sex ❑ M ❑ F Age ____ Birthday ______________

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, please describe it:

____

____

____

____

Has your child been treated on an emergency basis? ❑ Yes ❑ No

Please describe: ______________________

____

PREGNANCY HISTORY

Did you experience any complications during your pregnancy? (check all that apply)

❑ Back/Other Pain ❑ Gestational Diabetes ❑ Pre/Eclampsia ❑ Strep B ❑ Nauseau/Vomitting
❑ Pre-Term ❑ Fatigue ❑ Swelling ❑ Other (please describe) ______________

____

BIRTH HISTORY

Type of birth (check all that apply):

❑ Hospital ❑ Birth Center ❑ Home ❑ Normal / Vaginal ❑ Breech
❑ Cesarean ❑ Scheduled/Induced ❑ Epidural

Problems during labor / delivery? ______________________

____

❑ Antibiotics ❑ Congenital Anomalies ❑ Failure to Thrive ❑ Jaundice ❑ Meconium
❑ Respiratory Distress ❑ Extended Hospitalization ❑ Other ______________

GROWTH & DEVELOPMENT

Infant feeding: ❑ Breast ❑ Bottle ❑ Formula

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

At what age did the child:

Respond to sound: ______________ Crawl: ______________ Hold head up: ______________

Stand: ______________ Sit unsupported: ______________ Walk unsupported: ______________

CHILDHOOD DISEASES, ILLNESSES & VACCINATIONS

Has your child had (check all that apply)?:

❑ Chicken Pox	❑ Measles	❑ Rubeola
❑ Mumps	❑ Rubella	❑ Pertussis/Whooping Cough

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

❑ Allergies	❑ Broken Bones	❑ Digestive Issues (constipation/diarrhea)	❑ Hypertension	❑ Orthopedic Problems
❑ Anemia	❑ Chronic Ear Aches		❑ Jeuvenile Rheumatroid Arthritis	❑ Paralysis
❑ Arm Problems	❑ Colds/Flu	❑ Dizziness		❑ Poor Appetite
❑ Asthma	❑ Colic	❑ Fainting	❑ Joint Problems	❑ Ruptures/Hernias
❑ Back Aches	❑ Convulsions/Seizures	❑ Headaches	❑ Leg Problems	❑ Sinus Trouble
❑ Bed Wetting	❑ Delayed Speech	❑ Heart Trouble	❑ Neck Problems	❑ Tuberculosis
❑ Behavioral Problems	❑ Diabetes	❑ Hyperactivity	❑ Neuritis	❑ Walking Problems

Have you vaccinated your child?

❑ No ❑ Yes ❑ As scheduled ❑ Delayed Schedule

ALLERGIES, MEDICATIONS, SURGERIES & FAMILY HISTORY

ALLERGIES (list)

____

____

MEDICATIONS (list)

____

____

SURGERIES (list)

____

____

FAMILY HISTORY (list)

____

____

SIBLINGS

How many children do you have? ______________

Children's' Ages: ______________

Childrens' health concerns: ______________

____

Number of pregnancies: ______________

Are you currently pregnant? ❑ No ❑ Yes, I'm due: ______________

Health concerns regarding this pregnancy? ______________

____

Authorization for Care of Minor

I hereby authorize this clinic and its doctor(s) to administer care as they so deem necessary to my son/daughter/ward.

Signed: ______________ Witnessed: ______________ Date: ______________