ANCHOR

CHIROPRACTIC

Pediatric Intake and History

Patient Name: _____ **Date:** _____

Address: _____ **City:** _____ **Zip:** _____

Age: _____ **Date of Birth:** _____ **M / F**

Phone: _____ **Email:** _____

Mother's Name: _____ **Father's Name:** _____

Insurance Co.: _____ Subscriber Name: _____

Pregnancy and Birth:

Did you carry to full term? _____ Normal Vaginal Delivery? _____ C-Section?: _____

Forceps or Vacuum Extraction?: _____ Torticollis?: _____

Genetic disorders or disabilities?: _____

Any complications?: _____

As a baby/toddler, did any of the following occur?:

___ Fall from a change table
___ Tumble down stairs
___ Fall out of crib
___ Involved in car accident
___ Fall off playground equipment
___ Play in a Jolly Jumper@
___ Frequent ear infections
___ Tonsilitis
___ Reaction to vaccination
___ Frequent crying spells
___ Frequent fevers
___ Frequent bouts of diarrhea
___ Constipation
___ Sleeping problems
___ Frequent colds
___ Colic
___ Did not gain weight
___ Other_____

Please explain the above: _____

As a young child, did any of the following occur?:

___ Fall from a tree
___ Fall of a bicycle
___ Fall of playground equipment
___ Sports accident
___ Car accident
___ Stomach pains
___ Scoliosis
___ Bed wetting
___ Hyperactivity/Autism
___ Learning difficulties
___ Asthma
___ Allergies
___ Leg/knee pains
___ Other_____

Please explain the above: _____

_____

Tell us about any vaccinations your child has had: _____

_____

Any reactions to any of these? _____

_____

Has your child experienced any of the following:

___ Headaches	___ Numbness in arms/hands	___ Foot/ankle/knee pains
___ Dizziness	___ Arm/wrist pains	___ Tingling in arms/legs
___ Ringing in ears	___ Sleeping problems	___ Neck/back pains
___ Asthma	___ Allergies	___ Shoulder pains
___ Hyperactivity	___ Stomach problems	___ AGrowing Pains@
___ Fatigue	___ Weight gain/loss	___ Other _____

Please explain any of the above: _____

_____

Which of the problems you have checked off are the worst? _____

_____

Is this problem: Constant _____ **Intermittent** _____ **Occasional** _____

How long has it persisted? _____

When it is at its worst, how does it make your child feel? _____

What have you done about it that has NOT worked? _____

What makes it worse? _____

What effect does this problem have on your child's activities? _____

_____

List any medications your child is currently taking: _____

Is there anything else you feel we should know? _____

_____

Authorization for Care of Minor: I hereby authorize the doctors of Anchor Chiropractic to administer care to my child as they deem necessary.

Signed: _____ Date: _____

HIPAA: Anchor Chiropractic conforms to the current HIPAA guidelines. You may request a copy of our HIPAA policy at the front desk. Please sign below to indicate you are aware of its availability.

Signed: _____ Date: _____

It is a pleasure to welcome you to our family of happy and healthy chiropractic kids! Please let us know if there is any way we can make you and your family more comfortable. We look forward to working with you to building better health!