PEDIATRIC CHIROPRACTIC INTAKE & HISTORY

Patient Information

Child's Name: _____ Date of Birth: _____ Age: _____

Address: _____ City: _____ Zip: _____

Gender: MALE or FEMALE

Parent / Guardian Information

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

Contact Number: _____ Contact Number: _____

Email Address: _____ Email Address: _____

Subluxation Related Complaints

Ages 0-3 -Please Circle ALL that apply:

- Back Pain / Arching
- Colic
- GERD/ Acid Reflux
- Constipation/ Diarrhea
- Seizures / Neurological Tics
- Prone to Sickness
- Earaches/ Infections
- Difficulty Nursing
- Dislikes Tummy Time
- Head Distortion
- Asymmetrical Features
- Intolerance to Foods/Formula
- Sleep Issues
- Failure to Thrive

Ages 4-17 - Please Circle ALL that apply:

- Back Pain
- Poor Posture
- Prone to Sickness
- Sleeping Issues
- Digestive Problems
- Asthma
- Allergies
- Scoliosis
- Bedwetting
- ADD/ ADHD
- Seizures/Neurological Tics
- Developmental Delays
- GERD/ Acid Reflux
- Earaches/ Infections
- Skin Problems/ Eczema

History / Reasons for seeking Chiropractic Care:

Has your child had any chiropractic care? YES or NO Date of last visit: _____

Reason / Concerns for seeking care in our office:

_____

_____

Are you concerned about developmental delays? Y / N If yes, please explain:

_____

_____

What is the biggest improvement you would like to see in your child:

_____

_____

Prenatal History

Place of Birth: ◯ Hospital ◯ Birthing Center ◯ Home Birth Care Provider: ◯ OBGYN ◯ Midwife ◯ Doula

Please give a brief summary of the birth (Including any possible complications, length of time in labor, prenatal health issues):

_____

_____

_____

Was / is your child breastfed? YES or NO

Did you have complications breastfeeding? YES or NO

If yes, please explain: _____

_____

Lifestyle Information

How would you rate your child's ability to physically move without any limitations or restrictions?

◯ Excellent ◯ Very Good ◯ Average ◯ Poor

How do you rate your child's diet or nutrition?

◯ Excellent ◯ Very Good ◯ Average ◯ Poor

How do you rate your awareness and effort to avoid environmental and chemical stresses and toxins for yourself and your child?

◯ Excellent ◯ Very Good ◯ Average ◯ Poor

How do you rate your child's phycological and emotional environment?

◯ Excellent ◯ Very Good ◯ Average ◯ Poor

On a scale of 1 - 5 (1 being the worst) how would you rank your child's overall health and wellness thus far?

On a scale of 1 - 5 (1 being the worst) how would you rank your priority for your family's health?

Authorization for care of a minor

Consent for Evaluation and Treatment of a Minor Child: Date: _____

I hereby authorize the doctors of Heskett Family Chiropractic to administer chiropractic care and related services to my child, as deem necessary with or without my presence. Furthermore, the Doctors will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Name of Minor Child: _____

Parent or Guardian (Print): _____

Parent / Guardian Signature: _____

OPTIONAL:
I grant permission for the individuals listed below to bring my child to appointments and to make necessary healthcare decisions on my behalf in my absence.

_____ Relationship: _____

_____ Relationship: _____

_____ Relationship: _____

_____ Relationship: _____