vaida
WELLNESS CENTER

INFANT/CHILD INTAKE FORM

PATIENT INFORMATION

Date _____/_____/_____

Child's Name _____
LAST FIRST MI

Sex ☐ Male ☐ Female Date of Birth ____/____/____ Age _____ Height_____ Weight_____lbs.

Address _____
City _____ State _____ Zip _____

Parent/Guardian Name(s) _____
Cell Phone (_____) _____ Work Phone (_____) _____
Home Phone (_____) _____ Best time to reach you _____
Parent/Guardian Email _____

IN CASE OF EMERGNCY, CONTACT
Name _____ Relationship _____
Primary Phone (_____) _____ Secondary Phone (_____) _____

REFERRAL INFORMATION

How did you hear about us? ☐ Facebook ☐ Family /Friend (Whom may we thank for referring you? _____)
☐ Internet Search ☐ Insurance ☐ Staff ☐ Other: _____

AUTHORIZATION FOR CARE OF A MINOR

Parent/Guardian Name: _____
I hereby authorize and consent to the chiropractic evaluation and care of my child.

Parent/Guardian Signature: _____ Date _____ /_____ /_____

PATIENT CONDITION

What health condition(s) bring your child to be evaluated by a chiropractor: _____
_____

When did this condition begin? _____ /_____ /_____ How did the problem start: ☐ Suddenly ☐ Gradually ☐ Post-Injury

How often does your child experience this condition? ☐ Constant ☐ Frequently ☐ Intermittent ☐ Occasionally

Does this condition interfere with: ☐ Sleep ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

Has your child received treatment for this condition before? ☐ No ☐ Yes
If Yes, Please Explain: _____

What makes the problem better? _____ What makes the problem worse? _____

HEALTH GOALS

What are the top three health goals for your child?
1._____
2._____
3._____

What would you like to gain from chiropractic care?
☐ Resolve existing condition ☐ Overall Wellness ☐ Both

PREVIOUS TREATMENT

Pediatrician: _____ Date of last visit: _____/_____ /_____

Previous Chiropractic Care: ☐ No ☐ Yes Name: _____ Date of last visit: _____/_____ /_____

Other Health Care Professional _____

Previous Diagnosis: _____

HEALTH HISTORY

Please mark any of the following conditions that your child currently experiences or has ever had:

☐ Abnormal bleeding
☐ Allergies
☐ Asthma/Wheezing
☐ Bed wetting
☐ Cancer
☐ Chicken Pox
☐ Child doesn't get along well with other children
☐ Colic
☐ Congenital heart defect
☐ Convulsions/Epilepsy
☐ Croup
☐ Dental problems
☐ Developmental problems
☐ Diabetes
☐ Diarrhea or Constipation
☐ Discipline problems
☐ Eczema/Skin Problems
☐ Emotional problems
☐ Ever eaten dirt, paint or plaster
☐ Eye problems
☐ Frequent colds or sore throats
☐ Frequent ear infections
☐ Handicaps/Disabilities
☐ Hearing problems
☐ Heart murmur
☐ Hemophilia
☐ Hepatitis
☐ High Blood Pressure
☐ High Cholesterol
☐ HIV/AIDS
☐ Irritable/temper problems
☐ Kidney/Bladder problems
☐ Mumps, Measles
☐ Nightmares/sleep problems
☐ Night sweats
☐ Pneumonia
☐ Reflux
☐ Rheumatic Fever
☐ Speech problems
☐ TB/Lung Disease
☐ Thumb Sucking
☐ Toilet training problems
☐

Please explain any medical issues that your child has: _____

_____

Labor and Delivery History:

Child's birth was?: ☐ Natural Vaginal Birth ☐ Scheduled C-Section ☐ Emergency C-Section

Child's birth was?: ☐ At Home ☐ At A Birthing Center ☐ At a Hospital ☐ Other:_____

At how many weeks was your child's birth? _____ Birth Weight: _____ Birth Height:_____

Please check any applicable interventions or complications:
☐ Breech ☐ Induction ☐ Pain Meds ☐ Epidural ☐ Episiotomy ☐ Vacuum Extraction ☐ Forceps

Were any of the following used throughout pregnancy? ☐ Doula ☐ Midwife ☐ Chiropractor

Any evidence of birth trauma? (bruises, odd shaped head stuck in birth canal, fast or excessively long birth, respiratory depression, cord around neck, other):_____

_____

_____

Growth and Development History:

Was/Is the child breastfed? ☐ No ☐ Yes If yes, how long?: _____ Difficulty with breastfeeding? ☐ No ☐ Yes

Did/does your child ever use formula? ☐ No ☐ Yes If yes, at what age?: _____ If yes, what type?: _____

Does your child frequently arch their neck/back, feel stiff, or band their head? ☐ No ☐ Yes

At what age did the child: Respond to sound:_____ Follow an object:_____ Hold their head up:_____ Vocalize:_____
Teethe:_____ Sit alone:_____ Crawl:_____ Walk:_____ Begin cow's milk:_____ Begin solid food:_____

Known food sensitivities/allergies: _____

Typical diet: ☐ Mostly whole, organic foods ☐ Pretty average ☐ High amount of processed foods

Number of meals each day _____ Number of snacks per day _____

Has your child been vaccinated? ☐ No ☐ Yes If yes, which ones and list reactions to them: _____

_____

Has your child ever been on any antibiotics? ☐ No ☐ Yes How many courses: _____

Please list any major illnesses, injuries, falls, auto accidents or surgeries including dates: _____

_____

How often is your child using screen time? (cell phone, ipad, computer/laptop, television) Hours per day _____