Leading Edge Chiropractic & Acupuncture, P.C.

Pediatric Chiropractic Intake Form

Patient (child) Information:

Name: _____ Date:_____

Address: _____

Sex: Male Female Date of Birth: _____ Height: _____ Weight:_____

Patient SSN: _____ Name of Parents/Guardian:_____

Home Phone: _____ Cell Phone:_____ Work Phone: _____

Email: _____

Whom may we thank for your referring? _____

Authorized Representative/ Parent/ Guardian: _____ Phone: _____

Present Complaint: _____

When did this begin? _____ Was there an accident or injury involved? Y N

Has your child had any past treatment for this complaint? Y N Describe:_____

Current Medications: _____

General Question/Prenatal History:

Any complications during pregnancy? Y N Explain: _____

Medications taken during pregnancy: _____ Cigarettes or alcohol during pregnancy: Y N

Birth Intervention: Forceps Vacuum C-Section

Complications during delivery? Y N Explain:_____

How many times has your child been prescribed antibiotics in the past 6 months?_____ Total during lifetime:_____

Has your child received vaccinations? Y N

Feeding History:

Breast Fed: Y N How long: _____

Formula Fed: Y N How long: _____

Introduced to: Solids at _____ months

Cows milk at _____ months

Food Allergies or Intolerances: Y N

List_____

Childhood Diseases:

Chicken Pox: Y N Age:_____

Rubella: Y N Age:_____

Rubeola: Y N Age:_____

Mumps: Y N Age: _____

Whooping cough: Y N Age:_____

Other:_____ Age:_____

Developmental History:

During the following times your child's spine is the most vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference). At what age was your child able to:

_____ Respond to Sound _____ Cross Crawl

_____ Respond to Visual Stimuli _____ Stand Alone

_____ Hold Head Up Alone _____ Walk Alone

_____ Sit Up Alone

Is/has your child been involved in any high impact or contact type of sports (ie: soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.)? Y N

Has your child ever been involved in a car accident? Y N Explain:_____

Other traumas not described above? Y N Explain:_____

Prior surgeries? Y N Explain:_____

Review of Systems

Please check if your child has had any of the following:

_____Headaches	_____Postural Imbalances	_____Growing Pains	_____Scoliosis	_____Tonsillitis
_____Asthmas	_____Torticollis	_____Ear Infection	_____Seizures	_____Sleep problems
_____Digestive problem	_____Bedwetting	_____PDD/ Autism	_____ADD/ADHD	_____Frequent Fever
_____Colic	_____Learning Difficculties	_____Acid Reflux	_____Hip Dysplasia	_____Allergies

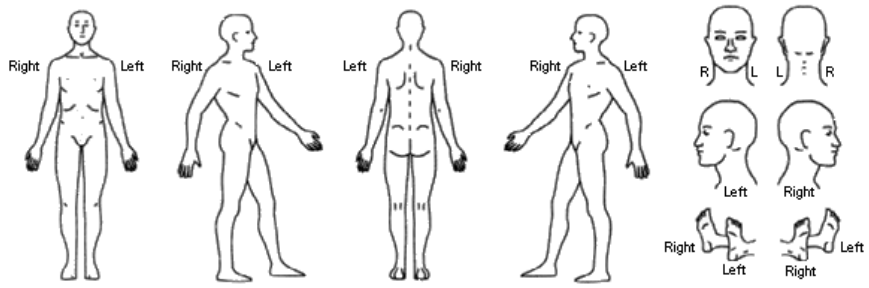
How would you rate your child's diet?_____Well Balanced _____ Average _____ High sugar/processed foods

Does your child consume artificial sweeteners? Y N

Number of hours your child sleeps:_____ hours per night _____ hours per day/naps

Sleep Quality: _____ Good _____ Fair _____ Poor

Indicate on the drawing below where you have pain/symptoms



AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. The following person(s) have my permission to receive my personal health information:

Guardian's Signature Authorizing Care: _____ Date: _____