Anchor Family Chiropractic

Chiropractic Pediatric Intake Form

Patient Information

First Name _____ Last Name _____

Street Address _____

Town/City _____ State _____ Zipcode _____

Home Phone _____ Cell _____

Email _____

Birth Date _____ Age _____ Sex _____

Height _____ Weight _____

Names of Parents/Guardians _____

How did you hear about our office? _____

Were you referred to this office? YES NO

If, yes by whom? _____

Health History

Purpose of contacting us? _____

How long has your child experienced this? _____

Is it getting better or worse over time? __ Better __ Worse

Name of your medical doctor _____ Date of last visit _____

Other health care professionals consulted for this problem _____

_____

Other health problems? _____

_____

Select any of the following that you are experiencing now or have experienced in the recent past:

__ Ear infections	__ Scoliosis	__ Eczema/Skin Problems	__ Temper Tantrums
__ Asthma/Allergies	__ Digestive Problems	__ Constipation/Diarrhea	__ ADD/ADHD
__ Colic	__ Growing Pains	__ Neck Pains	__ Allergies
__ Back Pains	__ Bronchitis/Upper Respiratory Infections		__ Other

If other, please specify _____

_____

Are you content with your child's present level of health? __ Yes __ No

Explain _____

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Previous Chiropractor _____

Reason for Visits _____

Has your child been treated by a physician for any condition in the previous 12 months? __ Yes __ No

If yes, explain _____

Is your child currently taking any medications? __ Yes __ No

If yes, explain _____

Does your child take any herbal or vitamin supplementation? __ Yes __ No

If yes, please list _____

Has your child ever been on an antibiotic? __ Yes __ No

If yes, please explain _____

Has your child received vaccinations? __ Yes __ No

Does your child exercise? __ Yes __ No

What type of exercise? _____

Prenatal History

Name of Midwife/Obstetrician _____ Ultrasound performed? __ Yes __ No

Medication during pregnancy? __ Yes __ No

Medication during labor/delivery? __ Yes __ No

If yes, please list _____

Were you induced? __ Yes __ No

Was your child at any time during your pregnancy in an intra-uterine constraining position such as:

__ Breech __ Transverse (side lying) __ Face/Brow Presentation

What type of delivery did you have? __ Vaginal __ C-Section

If C-section, was it planned or emergency? __ Planned __ Emergency

Were there any of the following used during delivery? __ Forceps __ Vacuum Extraction __ Other

If other, explain _____

Any complications during delivery? __ Yes __ No

_____

Location of birth: __ Hospital __ Birth center __ Home

Weight at birth _____ Length at birth _____

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Feeding History

Breast Fed __ Yes __ No

If so, how many months? _____

Formula Fed: __ Yes __ No

If so, type? _____

Introduced to solids at: _____ months Cow's milk at _____ months

Food Sensitivities _____

Developmental History

During the following times your child's spine is 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).

Hold head up _____ Sit up _____ Cross crawl _____

Walk alone _____

Has your child ever fallen from a high place? (bed, change table, sofa, down stairs, etc.) __ Yes __ No

If yes, please explain _____

Is/Was your child involved in any impact or contact sports? __ Yes __ No

If yes, please explain _____

Has your child ever been involved in a car accident? __ Yes __ No

If yes, please explain _____

Has your child ever been seen on an emergency basis? __ Yes __ No

If yes, please explain _____

Other traumas? __ Yes __ No

If yes, please explain _____

Prior surgery? __ Yes __ No

If yes, please explain _____

Childhood Illnesses

Please indicate if your child has experienced any of the following illnesses, and if so, at what age (year).

__ Chicken Pox	Age _____	__ Mumps	Age _____
__ Rubella	Age _____	__ Whooping Cough	Age _____
__ Chicken Pox	Age _____	__ Other	Age _____

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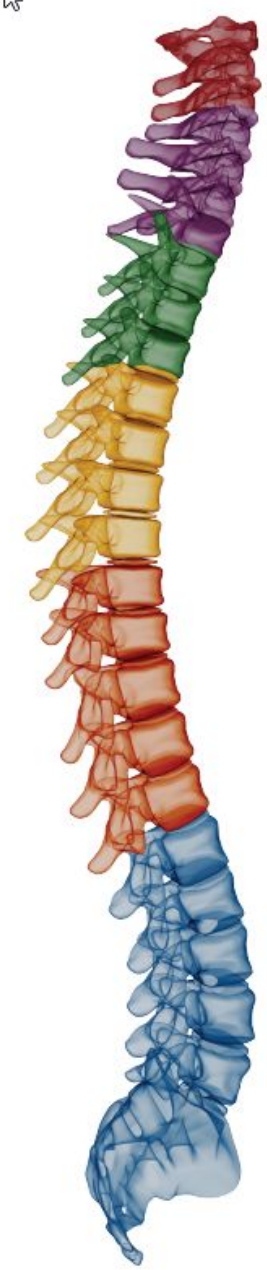

REGIONS	FUNCTIONS	SYMPTOMS	
		PAST / PRESENT	PAST / PRESENT
Cervical	• Autonomic Nervous System • ENT System • Vision, Balance & Coordination • Speech • Immune System • Digestive System • Nerve Supply to Shoulders, Arms & Hands • Sympathetic Nucleus • Metabolism	☐☐ Colic & Excessive Crying ☐☐ Ear & Sinus Infections ☐☐ Allergies & Congestion ☐☐ Immune Deficiency ☐☐ Headaches & Migraines ☐☐ Vertigo & Dizziness ☐☐ Sore Throat & Strep ☐☐ Swollen Tonsils & Adenoids ☐☐ Vision & Hearing Issues ☐☐ Low Energy & Fatigue ☐☐ Difficulty Sleeping ☐☐ Pain, Numbness & Tingling in Arms to Hands	☐☐ Epilepsy & Seizures ☐☐ Sensory & Spectrum ☐☐ ADD / ADHD ☐☐ Focus & Memory Issues ☐☐ Anxiety & Stress ☐☐ Balance & Coordination ☐☐ Speech Issues ☐☐ TMJ / Jaw Pain ☐☐ Stiff Neck & Shoulders ☐☐ Depression ☐☐ High Blood Pressure ☐☐ Poor Metabolism & Weight Control
Upper Thoracic	• Upper G.I. • Respiratory System • Cardiac Function	☐☐ Reflux / GERD ☐☐ Chronic Colds & Cough ☐☐ Asthma	☐☐ Bronchitis & Pneumonia ☐☐ Functional Heart Conditions
Mid Thoracic	• Major Digestive Center • Detox & Immunity	☐☐ Gallbladder Pain / Issues ☐☐ Jaundice ☐☐ Fever	☐☐ Indigestion & Heartburn ☐☐ Stomach Pains & Ulcers ☐☐ Blood Sugar Problems
Lower Thoracic	• Stress Response • Filtration & Elimination • Gut & Digestion • Hormonal Control	☐☐ Behavior Issues ☐☐ Hyperactivity ☐☐ Chronic Fatigue ☐☐ Chronic Stress	☐☐ Allergies & Eczema ☐☐ Skin Conditions / Rash ☐☐ Kidney Problems ☐☐ Gas Pain & Bloating
Lumbar, Sacrum & Pelvis	• Lower G.I. (Absorption & Motility) • Gut-Immune System • Major Hormonal Control	☐☐ Constipation ☐☐ Chrohn's, Colitis & IBS ☐☐ Diarrhea ☐☐ Bed-wetting ☐☐ Bladder & Urination Issues ☐☐ Cramps & Menstrual Issues ☐☐ Cysts & Endometriosis ☐☐ Infertility ☐☐ Impotency ☐☐ Hemorrhoids	☐☐ Sciatica & Radiating Pain ☐☐ Lumbopelvic / SI Joint Pain ☐☐ Hamstring Tightness ☐☐ Disc Degeneration ☐☐ Leg Weakness & Cramps ☐☐ Poor Circulation & Cold Feet ☐☐ Knee, Ankle & Foot Pain ☐☐ Weak Ankles & Arches ☐☐ Lower Back Pain ☐☐ Gluten & Casein Intolerance

Dr. Claire Boehmer | Anchor Family Chiropractic

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