Patient Information:

Date: _____ Patient Name: _____

Date of Birth: _____/_____/_____ Age: _____ Gender: ●Male ●Female
Approximate Height: _____ Approximate Weight: _____

Parent/Guardian Name(s): _____

Siblings: _____

Address: _____ City: _____ State: _____ Zip: _____

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

Email address: _____

May we: ☐ Text ☐ Call ☐ Email or ☐ None to remind you of your appointments?

Referred By: _____ (may we thank them for referral? Y/N)

Previous Providers:

Midwife/Obstetrician: _____

Pediatrician/Family MD: _____

Date of last visit: ____/_____/_____ Purpose:_____

Immunization History: _____

Number of doses of antibiotics your child has taken: During the past 6 months _____ During lifetime _____

Has your child been to a chiropractor before?: ☐ Yes ☐ No

If yes, who was the physician?: _____

Reason for leaving: _____

Is your child currently seeing any other physician or healthcare professional?: ☐ Yes ☐ No

If Yes, who is the provider: _____

Date of last visit: _____/_____/_____ Reason for visit: _____

Consent to treat:

Being the parent or legal guardian of this child, I hereby authorize this office and its doctors to examine and administer care to my son/daughter named_____ as the examining/treating doctor deems necessary.

I understand and agree that I am personally responsible for payment of all fees charged by this office for such care.

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

Parent/Legal Guardian Name: _____

Witnessed By: _____

Current Health and Habits:

(Please fill out the following to best ability)

I would describe my child's overall health as (check one box): ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Reason you are seeking care for your child at Renew Chiropractic: _____

_____

(Many children begin chiropractic care as a form of wellness/preventative care, simply to help their child function the best they can. If this is the case, you can skip down to the "Past Health History" part of this intake.)

What are the symptoms being experienced? _____

When did they begin: _____

Has anything like this occurred before?: ☐ Yes, when_____ ☐ No

Did this happen gradually or suddenly: _____

Have you found anything to make it better or worse? _____

Since it began, are symptoms getting better, worse, or no different?: _____

Has your child been seen by another healthcare provider for this condition?: ☐ Yes ☐ No

If Yes, who_____

What was the treatment: _____

What were the results: _____

Past Health History:

Has your child ever been hospitalized: ☐ No ☐ Yes, why: _____

_____

Has your child had any surgeries? ☐ No ☐ Yes, why: _____

_____

At what age, if ever, did this child suffer from the following childhood diseases?

Chickenpox_____ Mumps_____ Measles _____ Rubella _____

Roseola _____ Whooping Cough _____ Other _____

Is your child vaccinated? ☐ No ☐ Yes, on schedule ☐ Yes, on a delayed or alternate schedule

If yes, has there been any reactions to the vaccinations:

☐ None ☐ Fever ☐ Rash ☐ Pain at injection site ☐ Diarrhea ☐ Vomiting

☐Fatigue ☐ Excessive Crying ☐ Seizures ☐ Developmental delays or regression

☐ Other: _____

Has this child ever suffered from: ☐ None

□ Headaches	□ Colds/Flu	□ Problems Latching	□ Constipation	□ Growing Pains
□ Dizziness	□ Colic	□ Scoliosis	□ Diarrhea	□ Allergies
□ Fainting	□ Muscle Pain	□ Walking Trouble	□ Diabetes	□ Allergies
□ Seizures	□ Neck pain	□ Broken Bones	□ Hypertension	□ Allergies
□ Heart Trouble	□ Arm problems	□ Digestive Issues	□ Anemia	□ Allergies
□ Chronic earaches	□ Leg Problems	□ Poor appetite	□ Bed Wetting	□ Other
□Sinus Trouble	□ Joint problems	□ Stomach Aches	□ Behavioral Issues	□Other
□ Asthma	□ Backaches	□ Reflux	□ ADD/ADHD	□ Other

Delivery/Birth History: ☐ Pre-term, weeks gestation_____ ☐ Full Term

Was birth: ☐ Induced ☐ Pitocin ☐ IV Pain Meds ☐ Epidural ☐ Antibiotics

How long was Active Labor: _____ How long was pushing:_____

Were there any complications?: ☐ No ☐ Yes,_____

Type of Birth: ☐ Vaginal ☐ Forceps/Vacuum Extraction ☐ Planned Cesarean ☐ Emergency Cesarean

Location of Birth: ☐ Home ☐ Birthing Center ☐ Hospital ☐ Other

Presentation of child: ☐ Vertex (head down) ☐ Breech, type_____ ☐ Transverse ☐ Face/Brow

APGAR Score at Birth: _____ APGAR Score at 5 minutes: _____

Was there presence at birth of: ☐ Jaundice (yellow skin color) ☐ Cyanosis (blue skin color ☐ None

Birth Weight:_____ Birth Length:_____

Growth and Development:

At what age did the child:

Respond to sound_____ Follow an object with his/her eyes_____

Hold head up_____ Sit Alone_____ Crawl_____ Stand _____

Has your child experienced trauma (motor vehicle accidents, broken bones, falls off beds/changing tables/down stairs, or other accidents)?: _____

_____

Has your child ever suffered the following spinal traumas?: ☐ None

□ Fall in baby walker	□ Fall from bed/couch	□ Fall off skateboard/skates/skiis
□ Fall from crib	□ Fall off swing	□ Fall off bicycle
□ Fall from highchair	□ Fall off slide	□ Fall down stairs
□ Fall from changing table	□ Fall off monkey bars	□Other

Is/has your child been involved in any high impact or contact sports (soccer, football, gymnastics, cheerleading, basketball, baseball, martial arts, etc)? ☐ Yes ☐ No

Has your child ever been seen on an emergency basis? ☐ No ☐ Yes, explain: _____

_____

Eating Habits and Activity Level:

Has your child been breastfed?: ☐ Yes, currently ☐ Yes, but not anymore ☐ No

If Yes, how long: _____ Any difficulties?: _____

If No, what type of formula is used: _____

What are your child's favorite foods?: _____

Does your child eat:

☐ Dairy ☐ Gluten/Wheat ☐ Sugar ☐ Eggs ☐ Soy ☐ Caffeine

Does your child drink water? ☐ Yes ☐ No How much?: _____

Does your child play outside? ☐ Yes ☐ No How long?: _____

What are your child's favorite activities?: _____

Does your child watch TV?: ☐ Yes ☐ No How many hours/day?: _____

Number of hours Sleeping per night: _____

Quality of Sleep: ☐ Good ☐ Fair ☐ Poor

Number of naps per day: _____ Length of naps: _____

Quality of Sleep: ☐ Good ☐ Fair ☐ Poor

Is there a preferred sleeping position?: _____

Is there anything else you would like to discuss with us at this point?: _____

_____

_____

_____

_____