SAFE HARBOR CHIROPRACTIC

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PEDIATRIC CHIROPRACTIC INTAKE FORM

(Please Print Clearly)

CHILD INFORMATION

Child's Full Name: _____

Date of Birth: _____ Age: _____ Sex: □ M □ F

Address: _____

City: _____ State: _____ Zip: _____

PARENT / GUARDIAN INFORMATION

Mother/Guardian Name: _____

Phone: _____ Email: _____

Father/Guardian Name: _____

Phone: _____ Email: _____

Emergency Contact (if different): _____

Phone: _____ Relationship: _____

Primary Pediatrician: _____

Phone: _____

REASON FOR VISIT

What concerns bring your child in today?

When did this concern begin? _____

Has your child received care for this issue before? □ No □ Yes

If yes, explain: _____

What are your goals for your child's care?

PREGNANCY & BIRTH HISTORY

Mother's age during pregnancy: _____

Pregnancy complications? □ No □ Yes
If yes, explain: _____

Medications during pregnancy? □ No □ Yes
If yes, list: _____

Delivery Type:
□ Vaginal
□ Assisted (Forceps/Vacuum)
□ Cesarean

Birth Trauma Noted? □ No □ Yes
Explain: _____

Birth Weight: _____ Birth Length: _____

Was baby admitted to NICU? □ No □ Yes

DEVELOPMENTAL HISTORY

Rolled Over: _____
Sat Up: _____
Crawled: _____
Walked: _____
First Words: _____

Any developmental delays? □ No □ Yes
Explain: _____

HEALTH HISTORY

Diagnosed with:
□ Ear Infections
□ Asthma
□ Allergies

□ ADHD
□ Autism Spectrum
□ Headaches
□ Scoliosis
□ Seizures
□ Other: _____

Past Hospitalizations/Surgery:

Current Medications:

Current Supplements:

Vaccination Status:
□ Up to Date
□ Delayed Schedule
□ Not Vaccinated
□ Prefer Not to Answer

TRAUMA / INJURY HISTORY

□ Falls
□ Car Accident
□ Sports Injury
□ Concussion
□ Playground Injury
□ Other: _____

Explain:

CONSENT FOR CARE

I understand chiropractic care supports nervous system function and overall health. I authorize Dr. Kelly Engel to examine and provide appropriate chiropractic care for my child.

Parent/Guardian Name (Print): _____

Signature: _____ Date: _____