PEDIATRIC INTAKE FORM - TRUE HEALTH CHIROPRACTIC

Date:________________ Account # ____________

Referred by: ____________________________

Name: __________________________________ Phone: _____________________

Address: ________________________________ City: _______________________ Zip: _____________

Birth date: ___________________ Age: _______ SS#:___________________________________

Primary reason for consulting our office: ____

____

Name of Pediatrician: _______________________ Satisfied with the care you received? Y___ N___

PRENATAL HISTORY:

List any problems during pregnancy: ____

List any complications during delivery: ____

Did mother have Ultrasound during pregnancy? Y___ N___

Did mother use any medication during pregnancy? Y___ N___

Location of birth: Hospital____ Home____ Birthing Center____

FEEDING HISTORY:

Breast Feed? Y___ N___ If yes, how long? ____

Formula? Y___ N___ If yes, how long? ____

Nurse as well on the left side as the right side? ____

Food allergies of intolerance? ____

DEVELOPMENTAL HISTORY:

Age child responded to: Sound______ Visual______ Hold head up______ Crawling______

Sit up______ Standing______ Walking______

Any falls and at what age?____

Participate in any sports? ____

Accidents? ____

Child ever seen on an emergency basis? ____

Surgeries? ____

MEDICATIONS:

Number of doses of antibiotics: Past six months:______________ Total Lifetime:________________

Other medications: Past six months:____

Lifetime:____

Immunization History:____

ANY Vaccine Reactions:____