Pediatric Chiropractic Intake

Name ____ SSN ________________________

Address ____ Date of Birth _____________

City ___________________________ State _______ Zip _________ Phone ____________________________

Email ____

How were you referred to our office? ____

Has your child seen a chiropractor before? Y N If yes, who and when ____________________________________

Do you feel your previous chiropractic care was effective? Y N Please explain ______________________

____

Why have you decided to have your child evaluated?

- ☐ He/She is continuing care from another chiropractor.
- ☐ I recently had my spine checked and understand the value in getting my child checked.
- ☐ I have concerns about his/her health and I'm looking for answers.
- ☐ He/She has a specific condition and I've learned that chiropractic might be able to help.
- ☐ I want to improve my child's nervous system and make sure their immune system is functioning properly.

Circle any insurance coverage that may be applicable in this case:

Health Insurance   Health Sharing   Medicare   Auto Accident/Personal Injury   HRA/Flex

Terms of Acceptance: Our goals are to provide a detailed assessment of your child's current health status and provide you with resources to achieve health. Health is defined as a state of complete physical, mental, and social well-being not merely the absence of disease or infirmity. Chiropractic has only one goal: To restore the health of the body by removing spinal nerve impingements (also called joint fixations or chiropractic subluxations) which may be contributing or causing certain health conditions. To do this, we perform a procedure called a chiropractic manipulative treatment (CMT) or chiropractic adjustment and in most cases will also give advice for home care and nutrition to help your body heal and recover. We do not offer to diagnose or treat any disease as we only diagnose and offer treatment for chiropractic subluxations or musculoskeletal conditions.

HIPAA Notice: I understand and agree to allow this office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. If you would like to have a more detailed description of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA notice posted in the waiting room. The following person(s) have my permission to receive my personal health information:

____

Authorization and Release: I authorize payment of insurance benefits directly to this office. I authorize the doctor to release all information necessary to communicate with my insurance company, attorney, adjuster, healthcare providers, or payors to secure the payment of benefits. I understand that I am responsible for all costs of care regardless of insurance coverage or settlement. I give an assignment of health care lien against any claims or a third party to this office up to the owed balance for treatment. I also understand that if I suspend or terminate my recommended care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

I have read and understood the information above in Terms of Acceptance, HIPAA Notice, and Authorization and Release.

Print Patient Name ____ Date _______________

Signature ____

What brings you in today?: ____

Does your child appear to be in pain/discomfort: Y N How long have they been experiencing this?_______

Is it getting better, worse,or staying the same? _________ Was the onset sudden or gradual?___________

Has your child seen any other providers for this condition? _____________________________________

What treatment was recommended? ____

Please circle any signals your child's body has been communicating:

Asthma	Frequent Infections	Sinus Problems	Eczema/Rash	Food Sensitivity
Diarrhea	Constipation	Gas/Bloating	Head tilt	Scoliosis
Trouble feeding	Favoring one side	Colic/Crying	Failure to thrive	Slow/Absent reflexes
Bedwetting	Sleep problems	Night Terrors	Tip Toe walking	Asymmetric Crawl
Seizures	Tremors/Shaking	Autism/Spectrum	ADD/ADHD	Regression of milestones
Behavior Issues	Learning Disabilities			

Primary Care Physician

Name ____ Phone # _____________________

Address ____ Last Visit _____________

City _______________ State ____ Zip ________

Please list all medications/supplements your child is currently taking.

1. ____
2. ____
3. ____
4. ____
5. ____

Diet, health history, and sleep

Has your baby had any feeding difficulty? Y N Has your baby been checked for tongue/lip tie? Y N

How often does your baby get tummy time? ____

How often does your child have bowel movements? _______________________________________

Was your child breastfed? Y N How long? ___________

Was your child formula fed? Y N How long? ___________ What kind? ____________________

When was your child introduced to: Solid Foods? ________ Cow's Milk? ______ Pacifier? ______

Is your child using any special diets? GI Tube syringe or tube feed ketogenic

How many servings or grams of protein do they consume daily? _________

How many servings of fruits and vegetables do they consume daily? __________

Do they have any food allergies? ____

Has your child received all vaccines recommended by your pediatrician? Y N

Has your child had any adverse reactions to vaccines? ____________________________________

How many hours of sleep per night? ____

What position do they sleep in? Back Belly Side Other__________

Do you feel your child is developmentally appropriate for their age:

Intellectually? Y N Emotionally? Y N Physically? Y N

Prenatal History Adopted Prenatal history unknown Birth history unknown

Complications during pregnancy/delivery: Y N ____________________________________

Ultrasounds during pregnancy: Y N ____________________________________

Medications during pregnancy/delivery: Y N ____________________________________

Exposure to alcohol, tobacco, or drugs during pregnancy? Y N ___________________________

Was mother Group B Strep Positive? Y N Were antibiotics given during delivery? Y N

Baby was born:	at home	birthing center	hospital	
Baby born via:	vaginal birth	planned caesarian	emergency caesarian	
Baby presented:	headfirst	breech	transverse lie	
Intervention during delivery:	induction	membrane sweep	forceps	vacuum

Did your baby have any birth injuries, traumas, or genetic disorder/disability? Y N ______________________

Birth Weight ____________________ Birth Length ________________ APGAR scores ____ _____

EXAMINATION/DOCTOR USE ONLY

Motor Development/Milestones:

Age	Fine Motor	Gross Motor	Adaptive	Social	Communications
4w		Good head control when held erect	Occasional eyefollowing	Recognises facial form	Gutteral sounds
8w/2m		Head up when prone	follows	smiles	Early cooing
12w/3m	Open hands, grasps all objects	Assumes part of body weight with arms with prone	Regularly looks at objects in hand	Reaches for familiar objects	laughs
6m	Uses hand in raking motion	Rolling over	Transfers from hand to hand	Plays with hands	Speech is unclear
9m	Picks up objects using fingers/thumbs	Sits unsupported	Feeds from cup unassisted	Plays with feet, clearly shows joy/displeasure	Ma ma, da da, one or two recognizable words
12m	Well developed pincer grip, simultaneous turn 2-3 pages of book	Crawling established	Holds bottle unassisted	Finger feeds, plays peekaboo	Gestures, jargon
18m	Turns pages one at a time	Stands unsupported, walks with minimum assistance, runs well, walks upstairs	Builds tower of 2 cubes, feeds self with utensils, scribbles	Understands yes and no, pulls a wheeled toy	4-6 meaningful words, begins two word phrases

Spinal Screen

0-3m cervical lordosis/neck righting reflex
4-8m lumbar lordosis
9-14m gait development

Reflex	**Age Expected**	**Present**	**Absent**
Galant (prone flex toward stimulated spinal side) Perez (prone extend body with finger down spine) Asymmetric Tonic Neck ATNR (head turn to arm extend side) Plantar Response (toes up with foot stimulation) Placing (stepping) Moro (startle) Rooting Sucking Palmar Grasp (grab finger) Blink (response to cornea stim) Clonus (rapid flex foot with 5 beats) Vertical Suspension (baby holds pressure on feet, stepping) TLR (tilt head back when supine, arch back)	0-2m 0-6m 0-6m 0-18m 0-6w 0-4m 0-4m 0-4m 0-6m 0-12m 2-4m		

Notes: