DR. GENA CHIROPRACTIC NEW PEDIATRIC PATIENT INTAKE

Patient Name: _____ Today's Date: _____

Name of Parent(s)/Guardian(s): _____

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

Contact Telephone Numbers Home: ( )_____ Mobile: ( )_____

Email Address: _____

Sex (circle one): F M O Date of Birth: _____ Age: _____

Pediatrician: _____ Telephone ( ) _____

Primary Concern: _____

Have you seen another doctor for this? Yes No If yes, please list doctor's name(s) and prior treatments:

_____

Other health problems? _____

_____

YOUR CHILD'S HEALTH HISTORY

Please check √ any of the conditions that your child has suffered.

☐ Ear Infections	☐ Scoliosis	☐ Seizures	☐ Temper Tantrums
☐ Headaches	☐ Asthma	☐ Allergies	☐ Colic
☐ Growing/Back Pain	☐ Recurring Fever	☐ Chronic Cold	☐ Bed Wetting
☐ Chicken Pox	☐ Digestive Problems	☐ ADD/ADHD	☐ Constipation (BM)

Has your child seen a chiropractor before? Yes No If yes, whom/when? _____

Whom may we thank for referring you to our office? _____

Please list any previous surgeries, including date: _____

_____ N/A or None

Number of doses of antibiotics your child has taken:

During the last 6 months: _____ Total during lifetime: _____

List any medications that your child is taking: _____

_____ N/A or None

Vaccination History: _____

_____ N/A or None

Does anyone in your family have any medically-diagnosed conditions? If so, whom/which? _____

_____ N/A or None

INJURIES/TRAUMA

Has your child ever fallen head first from a high place during their first year of life?	Yes	No
Is/has your child ever been involved in any high impact or contact sports?	Yes	No
Has your child ever been involved in a car accident?	Yes	No
Has your child been seen on an emergency basis?	Yes	No

Other traumas not described above? _____

PLEASE CONTINUE ON NEXT PAGE →

DR. GENA CHIROPRACTIC NEW PEDIATRIC PATIENT INTAKE

Patient Name: _____ Today's Date: _____

PRENATAL HISTORY

Name of Obstetrician/Midwife: _____

Any complications during pregnancy? _____

Cigarette/Alcohol use during pregnancy? Yes No

Medications during pregnancy/delivery? Yes No If yes, please list: _____

_____

How many weeks did your pregnancy last? _____

Any complications during delivery? _____

How many hours was labor? _____

Cesarean Section? Yes No Emergency or Planned? _____

Birth Weight: _____ Birth Length: _____

FEEDING HISTORY

☐ Breast

☐ Bottle

☐ Both

☐ Allergies? _____

ADDITIONAL CONCERNS

Please list any additional concerns regarding your child in the space below:

This office conforms to the current HIPAA guidelines. You may request a copy of our HIPAA policy at the front desk.
Please initial to indicate you have been made aware of its availability: _____

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

_____ _____

Patient Name Printed Legal Guardian Name Printed

_____ _____

Legal Guardian Signature Date

OFFICE USE ONLY

Height: _____ Weight: _____ BP: _____ / _____ HR: _____

SAM Bilateral Scale → L: _____ R: _____ CS: _____