Pediatric Intake

Child Information

Patient's Name: _____
First Middle Last

Gender: _____ Birthdate: _____

Previous Chiropractor: _____ City: _____

When was the last visit to this chiropractor: _____

Reason for leaving: _____

Current Pediatrician: _____ City: _____

Parent Information

Parent's Name: _____
First Middle Last

Your Address: _____

City: _____ State: _____ Zip: _____

Parent's Social Security Number: _____ - _____ - _____ (This line must be filled out)

Phone Number: _____

Do you want to opt in for text message appt reminders: Yes No

Email Address: _____ Date of Birth: _____

Emergency Contact: _____ Phone: _____

Referred to our office by: _____

Other Parent's Name: _____
First Middle Last

Sibling's Name(s): _____

I understand and agree that all services rendered for the above patient are charged directly to me and that I am personally responsible for payment.

Signature: _____ Date: _____

Mainly for Moms:

1. **Pregnancy History:**

   Did you have difficulty conceiving? Y N Details? _____

   Did you carry full term? Y N

   Did you consume any alcohol during your pregnancy? Y N How Much? _____

   Did you smoke during your pregnancy? Y N How Much? _____

   Did you take any medications during your pregnancy? Y N

   Which medications? _____

   Any exposures to ultrasound? Y N How Many? _____

   Was your baby ever breech? Y N

   Were you ever under high amounts of stress or have anxiety during pregnancy? Y N

2. **Birth History:**

   Child's birth was at: Home Birthing Center Hospital

   Child's birth provider was: Midwife Obstetrician

   Did you have (circle all that apply): Induction Epidural Pain Meds Episiotomy
   Vacuum Extraction Forceps C-section

   Did the doctor / midwife pull or twist the baby? Y N Unsure

   Any birth complications or other interventions? _____

   How long was the labor? _____

   What was the baby's APGAR score? At birth: _____ at 5 min: _____

   Did the baby have to go to the NICU? Y N What for? _____

3. **Feeding History:**

   Did you breastfeed? Y N How Long? _____

   Was breastfeeding difficult and why? _____

   Did the baby prefer one breast over the other, or did you have to change positions to accommodate? Y N If so, which breast was favored? R L

   Did the baby have any latch issues or tongue / lip ties? _____

   Was a tie revision performed? Y N Laser? Y N

   What changes occurred after revision? _____

4. **Infant / Toddler History:**

As a baby / toddler (birth to 4 years), did any of the following occur?

___ Fall from a changing table
___ Tumble down stairs
___ Fall out of crib
___ Involved in a car crash
___ Fall off play equipment
___ Play in a “Jolly Jumper”
___ Frequent ear infections
___ Tonsilitis
___ Reaction to vaccination
___ Frequent crying spells
___ Frequent fevers
___ Frequent bouts of diarrhea
___ Constipation
___ Sleeping problems
___ Frequent colds
___ Colic
___ Did not gain weight
___ Other: _____

Please explain the above: _____

_____

_____

5. **Young Child History:**

As a young child (5-12 years), did any of the following occur?

___ Fall from a tree
___ Fall off a bicycle
___ Fall off play equipment
___ Sporting injury
___ Involved in a car crash
___ Stomach pains
___ Scoliosis
___ Other: _____
___ Bed wetting
___ Hyperactivity / ADD / ADHD
___ Learning difficulties
___ Autism
___ Asthma
___ Allergies
___ Leg / knee pains

Please explain the above: _____

_____

_____

6. **Chief Complaint:**

Which of the problems you have checked off is the worst? _____

_____

Is this problem: Constant Intermittent Occasional Cyclic

How long has it persisted? _____

When it is at its worst, how does it make your child feel? _____

_____

What have you done about it the has NOT worked? _____

_____

What makes it worse? _____

How does it affect his / her participation in daily activities? _____

_____

7. **Previous Healthcare:**

Describe any hospital stays: _____

Approximately how many times have antibiotics been prescribed and for what conditions?

_____

_____

List any medications your child is currently taking: _____

_____

What vaccinations has your child had? _____

_____

Any reactions to any vaccination? _____

_____

Were you told that you had a choice in vaccinating your child? Y N

Would you like information on the “other side” of this issue? Y N

Did your child have COVID? Y N

Was you child vaccinated for COVID? Y N # of boosters: _____

8. **To summarize, what is the purpose of this appointment?** _____

_____

_____

9. **Is there anything else you feel we should know?** _____

_____

_____

_____

10. **On a scale of 1-10, 10 being the highest, rate your commitment to helping us help your child be at their optimal wellness: _____**

Signature: _____ **Date: _____**

(Signature of Parent / Guardian required if patient is under age 18)

Patient Birth Records Release

I, _____, parent (or legal guardian) of the below
(parent's name)
mentioned child, hereby authorize and direct _____ to release the records relating to the birth of _____ to:
(child's name)

Flow Chiropractic
325 E 100 N, Ste B
Lehi, UT 84043
Phone: 385-389-6200
Fax: 385-389-6200

Child's date of birth: _____

May this signed consent form be your good authority to do so.

Signature: _____ Date: _____
(Signature of Parent / Guardian required if patient is under age 18)

Witness: _____