Dr Janine Kinahan, Chiropractor, 2740344F Dr Kathy Johansson, Chiropractor, 4611863J Dr Sophie Parish, Chiropractor, 5088145L Dr Todd Daniels, Chiropractor, 5092217A

Pediatric Intake Form

THANK YOU FOR TAKING THE TIME TO FILL IN THIS FORM

Patient Information

Childs Name	Parent/Guardians Name		
Postal Address	City	State	Postal Code
Home Phone	Mobile Phone		
Email	Childs Birthdate / /	Age	Sex M F

Who is your Primary Care Physician

Any other health Care Specialists?

List Any Drugs/medications/vitamins your child is taking:

Current Health Conditions

What Health Conditions bring your child to see us?

When did the condition begin? How did it start? ☐ Suddenly ☐ Gradually ☐ Post Injury

Has your child received care for this condition before? ☐ Yes ☐ No

If yes please explain

Is this condition ☐ Getting worse ☐ Improving ☐ Intermittent ☐ Constant ☐ Unsure

Health Goals For Your Child

What are your top three health goals for your child?

1. ______________________________
2. ______________________________
3. ______________________________

What would you like to gain from Chiropractic Care

☐ **Resolve Existing Condition**

☐ **Overall Wellness**

☐ **Both**

Pregnancy and Fertility History

Tell Us About Your Pregnancy

Any Fertility Issues ☐ Yes ☐ No If Yes, Please Explain ______________________________

Did Mother Smoke/ Drink ☐ Yes ☐ No If Yes, how many per week ______________________________

Did Mother Exercise ☐ Yes ☐ No If Yes, explain ______________________________

Was Mother Ill ☐ Yes ☐ No If Yes, explain ______________________________

Any Ultrasounds ☐ Yes ☐ No If Yes, how many ______________________________

Please Explain any notable episodes of mental or physical stress during your pregnancy

Please Explain any other concerns or notable remarks about your child's conception or pregnancy

Labour & Delivery History

Childs Birth was ☐ Natural Vaginal ☐ Scheduled C-Section ☐ Emergency C- Section At How Many Weeks was your child Born

Childs Birth was ☐ At Home ☐ At Birthing Center ☐ At Hospital Dr/ Obstetricians Name

Please Check Any Interventions/ Complications

☐ Breech ☐ Induction ☐ Pain Meds ☐ Epidural ☐ Episiotomy ☐ Vacuum extraction ☐Forceps ☐ Other

Please Describe any concerns about labour/ delivery

Childs Birth Weight APGAR Score at Birth APGAR Score after 5 minutes

Growth and Development History

Is/was your child ☐ Breastfed ☐ Formula Fed If Yes, type of formula? Difficulty with Breastfeeding? ☐ Yes ☐No

Did/Does your child ever suffer from colic, reflux, or constipation as an infant ☐ Yes ☐ No

if yes, explain

Did/Does your child frequently arch their neck/back, feel stiff, or bang their head ☐Yes ☐ No

If Yes, Please explain

At what age did the child Respond to sound____________Follow and object___________Hold their head up_Vocalize____ Sit Up_

________________Crawl____________ Walk__________ Eat Solids _________

List Any Food Intolerance or Allergies, and when they began

Please List Any Major Injuries, Accidents, Falls and/ or Fractures your child has sustained in his or her lifetime

Please list your child's hospitalization and surgical history, including year

Have you chosen to vaccinate your child? ☐ No ☐ Yes, on schedule ☐ Yes, on delayed schedule

Any Vaccine reactions?

Has your child received any antibiotics ☐ Yes ☐ No

If yes, how many times and the reason

Night terrors or difficulty sleeping ☐ Yes ☐ No

If Yes Please explain

Behavioral, social or emotional issues ☐ Yes ☐ No

If yes explain

How many hours per day does your child typically spend watching a TV, tablet, computer or phone?

How would you describe your childs diet? ☐ Mostly whole, organic foods ☐ Pretty Average ☐ High amount of processed food

Consent for Examination

I Consent to the examination of my child by the chiropractor.

Parent/ Guardian's Signature____Date _____________

*Patient Name*____________________________________*ID NUMBER*_________________