BARRETT FAMILY CHIROPRACTIC

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NEW PEDIATRIC INTAKE FORM

Name: ______________________________________ Sex: ❏Female ❏ Male Date of Birth: ___________________

Address: ____________________________ City:______________________ State: ________ Zip: ____________

Home Phone: ________________________

Mother's Name ______________________________ Cell/Work Phone #: ________________ /________________

Father's Name ______________________________ Cell/Work Phone #: ________________ /________________

Referred by: ____

Name of Pediatrician? ____ Phone #: _______________________

Responsible Party

Insurance Company: ____

Subscriber's Name: ____ Date of Birth: ___________________

Relationship to Patient: __________________________________ Name of Employer: _____________________

Current Health Condition

What is the reason for this visit? ____

Date of Onset? _________________________________ What caused the symptoms to start? Was it sudden or gradual? ____

What makes it better? ______________________________ What makes it worse? _______________________

Describe the type of symptom: ❏Aching ❏Sharp ❏Dull ❏Numb ❏Tingling ❏Shooting ❏Burning

Has your child ever received Chiropractic care before? ❏ Yes ❏ No If Yes, who? _________________________

Medications: ____

Allergies: ____

Prenatal Health History

Gestational age at birth (weeks at birth): __________ Birth Weight:_____________ Birth Length: _____________

Did you experience any of the following during your pregnancy?

❏Breech position ❏Accidents ❏Smoking ❏Severe Stress

❏Alcohol Consumption ❏Hypertension ❏Toxemia ❏Uncontrolled Diabetes

❏Placenta Previa

Type of Birth: ❏Vaginal ❏Planned C-Section ❏Emergency C-Section

Did your child experience any of the following during labor or delivery?

❏ Long or difficult labor ❏ Forceps/Suction/Vacuum ❏ Fetal Distress

❏ Low Oxygen or "Blue Baby" ❏ Breech Birth ❏ Rapid Delivery ❏Cord around neck ❏ Premature (2+ weeks)

Complications during delivery? ❏ No ❏ Yes What happened? ______________________________________

Location of Birth: ❏ Hospital ❏ Birthing Center ❏ Home Birth

Breastfed? ❏ No ❏ Yes For how long? ________________ Difficulty sucking or latching on? ❏ No ❏ Yes

Formula? ❏ No ❏ Yes Which kind? ____

Developmental History

During the following times your child's spine is very vulnerable to stress. At what age did your child start:

Rolling: _____ months Sitting: _____ months Crawling: ____ months Walking: ____ months

Did your child cross crawl? ❑ Yes ❑ No   Army crawl? ❑ Yes ❑ No

Has your child been involved in an auto accident? ❑ No ❑ Yes ____

Has your child even been seen on an emergency basis? ❑ No ❑ Yes ____

Prior Surgery? ❑No ❑ Yes

Check any of the following conditions your child has suffered from:

❑ Arm problems
❑ Acid reflux
❑ ADD/ADHD
❑ Anemia
❑ Anxiety
❑ Autism Spectrum Disorder
❑ Autoimmune disease
❑ Back aches
❑ Bed wetting/enuresis
❑ Behavioral problems
❑ Brain injury
❑ Bronchitis
❑ Cerebral palsy
❑ Chronic ear aches
❑ Cold/Flu
❑ Colic
❑ Bruxism (teeth grinding)
❑ TMJ/TMJD
❑ Constipation
❑ Diabetes
❑ Diarrhea
❑ Digestive problems
❑ Dizziness
❑ Down Syndrome (Trisomy 21)
❑ Dyslexia
❑ Growing Pains
❑ Headaches
❑ Heart problems
❑ High blood pressure
❑ Joint problems
❑ Leg problems
❑ OCD (Obsessive Compulsive)
❑ Eczema
❑ Multiple Sclerosis (MS)
❑ Hyperactivity
❑ Spina bifida
❑ Muscular Dystrophy (MD)
❑ Muscle pains
❑ Neck problems
❑ PDD/PDD-NOS
❑ Poor appetite
❑ Poor posture
❑ Scoliosis
❑ Seizures/convulsions
❑ Sinus trouble
❑ Skin problems
❑ Stomach aches
❑ Vision problems
❑ Erb's palsy
❑ Klumpke's palsy
❑ Brachial plexus injury
❑ Allergies ______________
❑ Other __________________
❑ Otitis media

According to the National Safety Council, approximately 50% of children fall from a high place during their first year of life (i.e. a bed, changing table, down stairs, etc.). Was this the case with your child? ❑Yes ❑ No

Authorization for Care of Minor

I, hereby, authorize Barrett Family Chiropractic and its Doctor, Susan Barrett-Naccarato, DC, to administer care to my child.

____ ____________________________

Signature Date

____

Printed Name of Signature Above

I realize that I am responsible for all fees charged by this office, and I agree to pay for all services provided.

____ ____________________________

Signature Date

____

Printed Name of Signature Above