COLUMBIA CHIROPRACTIC CENTER Keeping Columbia Moving.

Pediatric Intake Form (Birth to 12 years)

Patient Information:

Child's Name: _____ Parent's Name: _____

Address: _____ City: _____ State: _____

Zip: _____ Social Security #: _____Gender: M F

Race/Ethnicity:_____Birth Date:_____ Age:_____ Home Number:_____

Parent's Cell Number: _____ Parent's Email: _____

How would you like to be contacted: ☐ Home Phone ☐ Cell Phone ☐ Text ☐ Email

Name of Emergency contact: _____

Address of contact (if not the same as yours): _____

Phone # of contact: _____

How did you hear about our office?

☐Columbia Chiropractic Center Website ☐Search Engine:_____ ☐Community Event:_____

☐Health Talk:_____ ☐Law Firm:_____ ☐Dr Referral:_____

Patient Referral - who can we thank for sharing the benefits of care with you?_____

Child's Pediatrician: _____

When doctors work together it benefits you. May we have your permission to update your child's pediatrician regarding their care at this office? Yes or No (circle one)

Please check any and all insurance coverage that may be applicable in this case**:**

☐ Major Medical ☐ Worker's Compensation ☐ Medicaid ☐ Medicare ☐ Auto Accident

☐ Medical Savings Account & Flex Plans ☐ Other

Has your child been checked by a Doctor of Chiropractic? ☐ Yes ☐ No

If yes, please provide the name of the office & doctor: _____

Were x-rays taken? ☐ Yes ☐ No

Prenatal History:

Did you have any complications and when? _____

Did you smoke? ☐ Yes ☐ No

Did you consume alcohol? ☐ Yes ☐ No

Did you take medication? ☐ Yes ☐ No

Reason for medication? _____

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Birth History:

Did you have ultrasound during the pregnancy? ☐ Yes ☐ No
What was the frequency? _____

Place of birth: ☐ Home ☐ Birthing Center ☐ Hospital

Provider: ☐ Midwife ☐ OBGYN ☐ Other

Type of Birth: ☐ Vaginal ☐ C-Section

Were pain medications used? ☐ Yes ☐ No

Was labor induced? ☐ Yes ☐ No
If yes, why? _____

Birth trauma? ☐ Doctor Assisted ☐ Twisting and/or Pulling ☐ Vacuum Extraction ☐ Forceps
Newborn Trauma (medical procedures and test): _____

Did your child have a misshapen skull/head? ☐ Yes ☐ No

Were there purple markings on their face? ☐ Yes ☐ No

Did you breast feed your child? ☐ Yes ☐ No

Does your child prefer one breast over the other? ☐ Yes ☐ No

If yes, which side? ☐ Right ☐ Left

Does your child have any allergies? ☐ Yes ☐ No
If yes, please list: _____

Has your child been immunized? ☐ Yes ☐ No

Did your child have any negative reaction to the vaccination? ☐ Yes ☐ No

Has your child ever had any surgeries? ☐ Yes ☐ No
If yes, please elaborate: _____

Has your child been on antibiotics? ☐ Yes ☐ No
If yes, how often and what for? _____

Is your child currently taking any medication? ☐ Yes ☐ No

Is your child currently taking any vitamins? ☐ Yes ☐ No

Baby/Toddler (0-4):
Have any of the following occurred?

☐ Falling from a changing table ☐ Frequent crying spells ☐ Tumble down stairs ☐ Involvement in MVA

☐ Fall out of crib ☐ Fall off playground equipment ☐ Frequent ear infections ☐ Tonsillitis

☐ Reaction to vaccines ☐ Frequent fevers ☐ Frequent diarrhea ☐ Constipation ☐ Sleeping problems

☐ Repeated infections or colds ☐ Colic ☐ (+ or -) weight gain

☐ other (please explain): _____

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Child (5-12):

Has any of the following occurred?

☐ Fall from a tree ☐ Fall off of a bicycle ☐ Sports accident ☐ Car accident ☐ Stomach pains

☐ Scoliosis ☐ Bed wetting ☐ Fall on playground ☐ Hyperactivity/Autism ☐ Learning difficulties

☐ Asthma ☐ Allergies ☐ Leg/Knee pain

☐ Other (please explain): _____

Which of the above bothers your child the most? _____

When did it begin? _____

Is it getting worse? ☐ Yes ☐ No

Effect on activity? ☐ Not at all ☐ Somewhat ☐ Always

Is the pain: ☐ Constant ☐ Intermittent ☐ Cyclic

Does your child participate in any of the following?

☐ Soccer ☐ Football ☐ Gymnastics ☐ Karate

☐ Hockey ☐ Lacrosse ☐ Basketball ☐ Dance

☐ Wrestling ☐ Baseball/Softball ☐ Volleyball ☐ Tennis

☐ Swimming ☐ Rugby ☐ Other: _____

How would you rate your child's diet? ☐ Well balanced ☐ Average ☐ High sugar/processed foods

Does your child consume artificial sweeteners? ☐ Yes ☐ No

Fluoridated water? ☐ Yes ☐ No

Number of hours your child sleeps? _____hours/day

Sleep quality? ☐Good ☐ Fair ☐ Poor

AUTHORIZATION

Consent for Treatment

Assignment & Release *- By signing below, I authorize Columbia Chiropractic Center to release medical records required by my insurance company(s). I authorize my insurance company(s) to pay benefits directly to Columbia Chiropractic Center and I agree that a reproduced copy of this authorization will be as valid as the original. I understand that I am responsible for any amount not covered by my insurance, or any amount for a patient for which I am the guarantor. I agree that I will be responsible for any collection agency or attorney fees incurred. I understand that by signing below, I am giving written consent for the use and disclosure of protected health information for treatment, payment, and health care operations.*

By signing below, I give my informed consent for examination and the performance any tests or procedures needed. If patient is a minor, by signing I give consent for examination, tests and procedures for the above minor patient

Name of Patient:_____Date:_____

Signature of Patient/Legal Guardian:_____