Steele Chiropractic Pediatric Intake Form

1218 Ellis St Kewaunee, WI 54216

(920) 388-3440

About the Child

Name_______________________________ Age________ Date of Birth___________________

Gender □ Male □ Female Height________ Weight________

Address:____

City/State/Zip:____

Mother's name and phone #____

Father's name and phone #____

How did you hear about us____

Preferred language________________ Race__________ Ethnicity_________ Smoking status________________

Reason for Visit

Describe in detail reason for today's visit____

____

□ Sports □ Auto □ Fall □ Wellness Care □ Other (please specify)______________________________

When did this begin?__________________________ Experienced before □ Yes □ No

□ Getting better □ Worse □ Staying the same

Pain Level 1-10 ______ Type of pain: □ Tight □ Ache □ Sharp □ Tingling □ Numb

Does the problem/pain interfere with: □ School □ Playing □ Exercise/sports

□ Sleep □ Daily routine

Anything make it better? (ice, heat, pain meds…)____

Anything make it worse?____

Health Concerns

□ Anxiety □ Depression

□ ADD □ ADHD

□ Allergies □ Sinus problems

□ Asthma

□ Back pain □ Neck pain □ Joint pain

□ Bed wetting

□ Colic □ Acid Reflux

□ Concussion □ Torticollis

□ Constipation □ Diarrhea

□ Dizziness

□ Ear infections

□ Fatigue □ Sleep issues

□ Headaches □ Migraines

□ Nausea □ Vomiting

□ Overweight □ Underweight

□ Scoliosis

□ Seizures

□ Torticollis □ Head tilt

□ Other____

Has your child seen a chiropractor before? □ Yes □ No

Previous surgeries____

Previous broken bones____

Allergies____

Medications (Name <u>and</u> what they are used for):

1.________________________________ 2.________________________________

3.________________________________ 4.________________________________

5. ________________________________ 6.________________________________

Vitamins/Supplements:

□ Multivitamin □ Fish Oil/Omega 3 □ Vitamin D □ Probiotics

□ Other____

____

Lifestyle Habits

Does your child exercise daily? □ Yes □ No

Does your child have difficulty sleeping? □ Yes □ No

Does your child eat balanced meals? □ Yes □ No

Prenatal History (fill out if child is 3 years old or younger)

During pregnancy, did the mother: □ Experience significant illness, difficulties, or trauma?_______________

____

□ Take any drugs/medications?_________________________________

____

Did any of the following happen during delivery?

□ Labor was induced □ Premature Delivery □ Forceps/vacuum extraction

□ C-section □ Additional complications

Explain____

____

□ Formula-fed □ Breast fed □ Food Allergies/Intolerances List: _______________________

Parent/Guardian's signature__________________________________ Date_____________________