PACIFIC LIFE
CHIRO

PEDIATRIC INTAKE – AGES 10 AND UNDER

Child's Name: _____ Today's Date: _____

Age: ____ Date of Birth: _____ Gender: ____ Personal Health Number: _____

Address: _____ City/Prov: _____ Postal Code: _____

Birth Weight: _____ Birth Height: _____ Current Weight: _____ Current Height: _____

How would you prefer we contact you for appointment reminders? Text ☐ Email ☐ Phone ☐

Who can we thank for referring you to our office? _____

Parent/Guardian Contact Information

Name: _____ Phone: _____ Email: _____

Date of Birth: _____ Insurance Company: _____

Name: _____ Phone: _____ Email: _____

Date of Birth: _____ Insurance Company: _____

Doctor Information

Pediatrician/Family MD: _____ Office Location: _____

Last Visit: _____ Reason for Visit: _____

Birth Information

Were there any complications during pregnancy? _____

Were any medications taken during pregnancy? Please List: _____

Were there any complications during the birthing process? _____

Length of labour: _____ Length of delivery: _____

Check what applies:

☐ C-Section	☐ Epidural/Delivery Meds	☐ Home Birth	☐ Hospital Birth
☐ Formula	☐ Breast Feeding	☐ Premature	☐ Induction
☐ Bruising	☐ Breech Presentation	☐ Forceps	☐ Vacuum

Child's Current Condition

As a family chiropractic office, it is our goal that our practice members, both young and old, have optimal spinal health.

☐ Please check if your child has no symptoms or complaints and is here for a wellness based spinal health assessment. If there are specific concerns that you may have, please proceed to the next page.

Please describe the condition as best you can:

	Health Concern i.e. Body part, trauma	**Frequency** Constant, daily, intermittent	**Pain 0-10** 10 = Severe	**Relieves Symptoms** Sitting, lying down, etc.	**Worsens Symptoms** Sitting, lying down, etc.
1					
2					
3					

When did the problem(s) begin? _____ Gradual ☐ Sudden ☐ Unknown ☐

Any bowel or bladder problems since this began? _____

Have you seen any other doctors for this problem? Y ☐ N ☐ If yes, when? _____

What were the results of any past treatment? _____

How is the problem now? Rapidly Improving ☐ Improving Slowly ☐ About the Same ☐ Worse ☐

Please list any vitamins, supplements or herbs your child takes: _____

Please list any medications or antibiotics that have been taken within the last 6 months:

_____

Has your child sustained an injury from a motor vehicle collision? Y ☐ N ☐

Please detail any serious falls or fractures your child has suffered (i.e. fall from crib, chair, stairs):

_____

Please detail any surgeries, hospitalizations or medical interventions your child has undergone:

_____

Please note any developmental or milestone delays your child has experienced: _____

_____

Has your child been formally diagnosed with any specific conditions? Y ☐ N ☐

If yes, please list: _____

Symptoms – Please check any that apply:

☐Neck problems
☐Arm problems
☐Leg problems
☐Joint problems
☐Backaches
☐Scoliosis
☐Orthopedic problems
☐Poor posture
☐Muscle pain
☐Growing pains
☐Walking trouble
☐Poor balance

☐Headaches
☐Dizziness
☐Fainting
☐Seizures
☐Heart trouble
☐Chronic earaches
☐Sinus trouble
☐Hypertension
☐ADD / ADHD
☐Problems sleeping
☐Bed wetting
☐Hearing Issues

☐Ruptures / Hernia
☐Asthma
☐Anemia
☐Colic
☐Digestive disorders
☐Poor appetite
☐Stomach aches
☐Reflux
☐Constipation
☐Diarrhea
☐Frequent Colds / Flu
☐Fluid in ears