Pediatric Intake Form

Child's Last Name:	Child's First Name:	Date:

Please check the type of care desired:

- Family Health/Prevention
- Temporary Relief
- Stabilization
- Doctor's Advice

Is this appointment related to an:

- Auto Accident
- Injury on the Job? (If yes, please call before continuing)

How did you hear about Shine?

PERSONAL INFORMATION

Child's First Name: | M.I. | Child's Last Name:

Preferred Name: | Birth Date: | Age: | Sex:

Parent's Name(s):

Address:

City: | State: | Zip

Primary Phone: | Alternate Phone: | Email

Siblings' Names & Ages

REASON FOR SEEKING CARE

What is your reason for seeking care with Shine Chiropractic?

When/how did this first begin?

What aggravates your concern? | What alleviates your concern?

Is the condition worse during certain times of the day? If yes, when?

- Y
- N

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Have you seen any other providers for this condition? (List all providers & any treatments or diagnosis)

Is there anything else about your child's current condition you feel the doctor should know?

Do you have any other health concerns for your child?

DEVELOPMENTAL HISTORY

Mom's Pregnancy: (check all that apply)

- Tobacco
- Alcohol
- Medications
- Special Diet
- If adopted & no details are known check here
- Recreational drugs
- Falls/Injuries
- Abuse (any type)
- Complications/Illness

Explain any boxes checked above:

Birth: check all that apply

Third Trimester Presentation: Vertex / Breech / Transverse / Facial/Brow / Posterior

Type of Birth: Vaginal / Forceps / Vacuum / Cesarean (ER or planned?)

Interventions: Medication / Epidural / Ruptured Membranes

Delivery Location:

OB/Midwife Name:

Other Details:

Breast Fed: Y / N How Long? ____________

Formula Fed: Dairy / Other Please explain: ____________

Breastfeeding issues / Reason formula fed?

Age when solids were introduced:

Age when cow's milk was introduced:

Texture sensitivities? Y / N

Food sensitivities:

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Allergies:

Foods: ______________________ Medications: ______________________

Other: ______________________

Explain:

Has your child ever been hospitalized or had surgery? If yes please explain:

Y N

Does your child interact well with others? If no please explain:

Y N

Physical, emotional, or sexual abuse?

Y N

Explain:

Nightmares or night terrors?

Y N

Explain:

Shoulder or elbow dislocations?

Y N

Played in a hanging/bouncy swing?

Y N

Plays on a trampoline?

Y N

Can your child currently: (check all that apply)

- Sit Independently
- Crawl forward with opposite hand and knee
- Stand Independently
- Walk Independently
- Pinch
- Jump
- Skip
- Roll Over
- Read
- Write

Explain if necessary :

Your child's current bowel/bladder habits: (check all that apply)

- Diapers
- Toilet Training
- Constipation/diarrhea
- Bowel movement at least once daily
- Enuresis (bed wetting)

Explain:

Menarche (first menstrual cycle:

Y N If yes age? ________

Cramps/PMS? If yes please explain:

Y N

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HEALTH HISTORY

Mark all that apply with (N) for Now, (P) for Past

- ADD/ADHD
- Anemia
- Arm problems
- Asthma
- Auto accident
- Bed wetting
- Broken bones
- Changes in bowel/bladder
- Chicken Pox
- Colic
- Colds/Flu
- Concussion/Head injury
- Croup
- Diabetes
- Digestive problems
- Diphtheria
- Ear infections/Aches
- Eczema/Skin condition
- Heart/Valve issues
- Fifth Disease/Parovirus
- Growing pains
- Hand, foot, mouth dz
- Headaches
- Reflux/Gassy
- Hernia
- Learning disabilities
- Leg problems
- Measles
- Scarlet Fever
- Motor integration issues
- Mumps
- Muscle pain
- Neck or back pain
- Sinus/Allergies
- Pertussis/Whooping Cough
- Poor appetite
- Poor posture
- Other ______
- Rotavirus
- Rubella
- Rubeola
- RSV
- Other ______
- Scoliosis
- Seizures
- Sensory integration issues
- Sports injury
- Stomach aches
- Surgery
- Walking trouble
- Other/Family History ______

Explain any boxes checked above:

Providers: (office & doctor/provider name, last visit date & reason)

Vaccines:

- CDC Full
- Delayed Full
- Modified
- None

Medications (name and reason):

Supplements (name and reason):

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CHILD'S DIET / MOM'S DIET IF BREASTFED

	Daily/High	Weekly/Moderate	Monthly or less/Low	None/Never
Dairy (milk, yogurt, cheese)	☐	☐	☐	☐
Meat	☐	☐	☐	☐
Vegetables	☐	☐	☐	☐
Fruit	☐	☐	☐	☐
Gluten (flour, wheat, pasta)	☐	☐	☐	☐
Soy	☐	☐	☐	☐
Sugar	☐	☐	☐	☐
Soda/Energy drinks	☐	☐	☐	☐
Fast food	☐	☐	☐	☐
Water	☐	☐	☐	☐

Please check all that apply if mom is breastfeeding:

☐ Caffeine ☐ Coffee ☐ Tea ☐ Alcohol

☐ Tobacco ☐ Medications of any type ☐ Supplements

Explain any boxes checked above:

HOUSEHOLD HABITS

Do you use **filtered water?**	Do you eat **organic foods?**	Do you use **organic toiletries?**	Do you filter **your air?**
○ Y ○ N	○ Y ○ N	○ Y ○ N	○ Y ○ N

Please explain any boxes checked "Y" above::

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CHIROPRACTIC HISTORY

Has your child ever been adjusted before? ○ Y ○ N	How old were they the first time they were adjusted?	
Doctor's office or name?	When was their last adjustment?	Technique used if known:

Reason for visit:

Result & reason for change?

Is there anything else that may help us to understand your child, their history, or needs that have not been discussed on this questionairre? Please explain:

PERMISSION TO TREAT A MINOR

I (parent, guardian) ____, give permission to Shine Chiropractic to examine, X-Ray (if necessary), and treat ____.

____ ________________

Parent / Guardian Signature Date