



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

REASON FOR SEEKING CARE

What is your reason for seeking care with Shine Chiropractic?

When/how did this first begin?

What makes the problem **worse**?

What makes the problem **better**?

Have you received care for this problem before? Y N

If yes, please explain:



Pediatric Intake Form

PG 02

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:



Pediatric Intake Form

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 bouncy swing or walker?

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



Pediatric Intake Form

HEALTH HISTORY

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

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



Pediatric Intake Form

CHILD'S DIET / MOM'S DIET IF BREASTFED

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

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**?

- Y N

Do you eat **organic foods**?

- Y N

Do you use **organic toiletries**?

- Y N

Do you **filter your air**?

- Y N

Please explain any boxes checked "Y" above::



Pediatric Intake Form

PG 06

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 questionnaire? 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