STEVENS CHIROPRACTIC & WELLNESS CENTER

Pediatric Chiropractic Intake Form

Patient (Child) Information:

Name: ____ Date: ___________________________________
Address: ____
Sex: Male Female Date of Birth: _______________ Height: _________________ Weight: ______________
Name(s) of Parents/Guardian: ____
Home Phone: _____________________ Cell Phone: ______________________ Work Phone: ____________________
Email: ____
How did you hear about our office? ____

Present Complaint: ____

When did this begin? ______________________________________ Was there an accident or injury involved? Y N Has your child had any past treatment for this complaint? Y N Describe: ____
Current medications: ____

General Questions/Prenatal History:

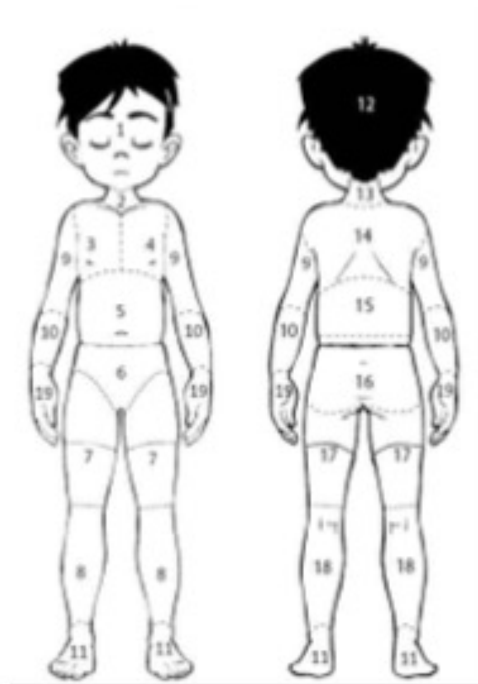
Birth: Vaginal C-Section (emergency / planned)
Complications during delivery? Y N Explain: ____
Genetic disorders or disabilities: ____
How many times has your child been prescribed antibiotics in the past 6 months? _______ Total during lifetime: ______
Has your child received vaccinations? Y N If yes, is it the full or graduated schedule? _________________________
Is/has your child been involved in any high impact or contact type of sports (ie: soccer, football, gymnastics, baseball, cheerleading, martial arts, etc)? Y N
Has your child ever been involved in a car accident? Y N Explain: ____
Other traumas not described above? Y N Explain: ____
Prior surgeries? Y N Explain: ____

DIET: How would you rate your child's diet? Well Balanced Average High sugar/processed foods
SODA: How many cans consumed/day? ________
SCREEN TIME (TV, Gaming, IPad, etc.): How many hours/day? ________
SLEEP: Number of hours your child sleeps: ________________ hours per night ________________ hours per day/naps
PILLOW: How many used______ years old______ MATTRESS: type________ years old_______
Sleep Quality: Good Fair Poor

Does your child wear a back pack? Y N Does he/she use both straps? Y N
Approximate weight of backpack ___________________

Past Chiropractic Care? Yes No Who? __________________________________ When? ______________________

1 – face
2 – neck
3 – left chest
4 – right chest
5 – stomach
6 – abdomen
7 – thighs
8 – legs
9 – upper arms
10 – lower arms
11 – feet
12 – back of head
13 – back of neck
14 – upper back
15 – middle back
16 – lower back
17 – back thighs
18 – back legs
19 – hands



Imagine this picture is your body. Can you color the area that is hurting you right now?

Review of Systems:

Please check if your child has had any of the following:

☐ Headaches
☐ Postural Imbalances
☐ Growing Pains
☐ Scoliosis
☐ Sensory Processing
☐ Asthma
☐ Torticollis
☐ Ear Infections
☐ Seizures
☐ Tonsillitis
☐ Sleep Problems
☐ Constipation
☐ Bedwetting
☐ Autism
☐ ADD/ADHD
☐ Frequent Fever
☐ Colic
☐ Learning Difficulties
☐ Acid Reflux
☐ Hip Dysplasia
☐ Allergies

Informed consent:

The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures, whatever he/she is suffering from - a latent pathological defect, illnesses or deformities - which would otherwise not come to the attention of the chiropractic physician.

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Authorization to Treat a Minor

I, ____ the undersigning parent/guardian having legal custody/ guardianship of ____, a minor, do hereby authorize Stevens Family Chiropractic and its Doctors to perform in judgment, any examination and chiropractic treatment, which is deemed necessary.

I clearly understand and agree that I am personally responsible for payment of all fees charged by this office. Any and all x-rays remain property of the clinic as part of patient's permanent record.

ACKNOWLEDGMENT

I have reviewed the notice of privacy practices (HIPPA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

COMMUNICATION

May we leave messages on any answering device, i.e. home answering machines or voicemails? ☐Yes ☐ N

Any specific written authorization you provide may be revoked at any time by writing to us at the above address.

Patient: ________________________________ ________________________________ ______________

Print Name | Signature: Parent/Legal Guardian | Date

Symptom Survey

List problems from most severe to least severe. Please be as specific as possible.

Problem #1.____

Location of pain:____

Severity of pain: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain imaginable) Pain is? Mild Moderate Severe

Progression (circle): same better worse How often is the pain present? Constant 50-75% 25-50% less than 25%

When did you notice the problem? ________________ What happened? ______________________

Better with (circle): rest ice heat stretching exercise pain relievers topical creams other___________

Worse with (circle): sitting standing walking bending twisting lifting movement other_____________

Quality of pain (circle): sharp shooting dull ache burning stiff stabbing throbbing numb sore

Does your pain radiate (example: travel into arms, legs etc.) Yes No Where? ______________________

What time of day is your problem the worse (circle): morning afternoon evening during sleep

What treatment have you received for this condition: medication physical therapy surgery chiropractic

other_________________________ Did it help? Y N

Problem #2.____

Location of pain:____

Severity of pain: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain imaginable) Pain is? Mild Moderate Severe

Progression (circle): same better worse How often is the pain present? Constant 50-75% 25-50% less than 25%

When did you notice the problem? ________________ What happened? ______________________

Better with (circle): rest ice heat stretching exercise pain relievers topical creams other___________

Worse with (circle): sitting standing walking bending twisting lifting movement other_____________

Quality of pain (circle): sharp shooting dull ache burning stiff stabbing throbbing numb sore

Does your pain radiate (example: travel into arms, legs etc.) Yes No Where? ______________________

What time of day is your problem the worse (circle): morning afternoon evening during sleep

What treatment have you received for this condition: medication physical therapy surgery chiropractic

other_________________________ Did it help? Y N

Problem #3.____

Location of pain:____

Severity of pain: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain imaginable) Pain is? Mild Moderate Severe

Progression (circle): same better worse How often is the pain present? Constant 50-75% 25-50% less than 25%

When did you notice the problem? ________________ What happened? ______________________

Better with (circle): rest ice heat stretching exercise pain relievers topical creams other___________

Worse with (circle): sitting standing walking bending twisting lifting movement other_____________

Quality of pain (circle): sharp shooting dull ache burning stiff stabbing throbbing numb sore

Does your pain radiate (example: travel into arms, legs etc.) Yes No Where? ______________________

What time of day is your problem the worse (circle): morning afternoon evening during sleep

What treatment have you received for this condition: medication physical therapy surgery chiropractic

other_________________________ Did it help? Y N

#4. Additional Complaints (use back of sheet if needed)

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____
____
____
____

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