

PEDIATRIC INTAKE & HISTORY



Landriault

CHIROPRACTIC HEALTH CENTRE
CENTRE DE SANTÉ CHIROPATIQUE

PATIENT INFORMATION

Patient Name _____

Mother's Name _____

Address _____

Mother's Occupation _____

City _____ State _____

Mother's Phone Home _____

Phone _____ Mother's Email _____

Cell Phone _____

Email _____

Father's Name _____

Sex M F Age _____ Birthday _____

Father's Occupation _____

IN CASE OF EMERGENCY, CONTACT

Father's Phone Father's _____

Name _____

Email _____

Relationship _____

Who may we thank for referring you? _____

Contact Number _____

HOW CAN WE HELP YOUR CHILD?

Wellness Checkup Other: _____

If your child is already experiencing a symptom, please describe it:

Has your child been treated on an emergency basis? Yes No

Please describe: _____

PREGNANCY HISTORY

Did you experience any complications during your pregnancy? (check all that apply)

- Back/Other Pain Gestational Diabetes Pre/Eclampsia Strep B Nauseau/Vomitting
 Pre-Term Fatigue Swelling Other (please describe) _____

BIRTH HISTORY

Type of birth (check all that apply):

- Hospital Birth Center Home Normal / Vaginal Breech
 Cesarean Scheduled/Induced Epidural

Problems during labor / delivery? _____

- Antibiotics Congenital Anomalies Failure to Thrive Jaundice Meconium
 Respiratory Distress Extended Hospitalization Other _____

GROWTH & DEVELOPMENT

Infant feeding: Breast Bottle Formula

Number of hours of sleep each night: _____ Quality of sleep: _____

At what age did the child:

Respond to sound: _____ Crawl: _____ Hold head up: _____

Stand: _____ Sit unsupported: _____ Walk unsupported: _____

CHILDHOOD DISEASES, ILLNESSES & VACCINATIONS

Has your child had (check all that apply)?:

- Chicken Pox Measles Rubeola
 Mumps Rubella Pertussis/Whooping Cough

Has your child ever suffered from (check all that apply)?:

- | | | | | |
|--|---|--|---|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Digestive Issues
(constipation/diarrhea) | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Orthopedic Problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Chronic Ear Aches | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Juvenile
Rheumatoid Arthritis | <input type="checkbox"/> Paralysis |
| <input type="checkbox"/> Arm Problems | <input type="checkbox"/> Colds/Flu | <input type="checkbox"/> Fainting | <input type="checkbox"/> Joint Problems | <input type="checkbox"/> Poor Appetite |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Colic | <input type="checkbox"/> Headaches | <input type="checkbox"/> Leg Problems | <input type="checkbox"/> Ruptures/Hernias |
| <input type="checkbox"/> Back Aches | <input type="checkbox"/> Convulsions/Seizures | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Neck Problems | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Delayed Speech | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Neuritis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Behavioral Problems | <input type="checkbox"/> Diabetes | | | <input type="checkbox"/> Walking Problems |

Have you vaccinated your child?

- No Yes As scheduled Delayed Schedule

ALLERGIES, MEDICATIONS, SURGERIES & FAMILY HISTORY

ALLERGIES (list)

MEDICATIONS (list)

SURGERIES (list)

FAMILY HISTORY (list)

SIBLINGS

How many children do you have? _____

Number of pregnancies: _____

Children's Ages: _____

Are you currently pregnant? No Yes, I'm due: _____

Children's health concerns: _____

Health concerns regarding this pregnancy? _____

Authorization for Care of Minor

I hereby authorize this clinic and its doctor(s) to administer care as they so deem necessary to my son/daughter/ward.

Signed: _____ Witnessed: _____ Date: _____