Rochester Chiropractic & Wellness

SCHOOL AGE INTAKE FORM

PATIENT INFORMATION

Date _____/_____/_____

Child's Name _____
LAST FIRST MI

Sex ☐ Male ☐ Female Date of Birth ____/____/____ Age _____ Height_____ Weight_____lbs.

Address _____
City _____ State _____ Zip _____

Parent/Guardian Name(s) _____
Cell Phone (_____) _____ Work Phone (_____) _____
Home Phone (_____) _____ Best time to reach you _____
Parent/Guardian Email _____

IN CASE OF EMERGNCY, CONTACT
Name _____ Relationship _____
Primary Phone (_____) _____ Secondary Phone (_____) _____

REFERRAL INFORMATION

How did you hear about us? ☐ Facebook ☐ Family /Friend (Whom may we thank for referring you? _____)
☐ Internet Search ☐ Insurance ☐ Staff ☐ Other: _____
Whom may we thank for referring you? _____

AUTHORIZATION FOR CARE OF A MINOR

Parent/Guardian Name: _____
I hereby authorize and consent to the chiropractic evaluation and care of my child.

Parent/Guardian Signature: _____ Date _____ /_____ /_____

PATIENT CONDITION

What health condition(s) bring your child to be evaluated by a chiropractor: _____
_____

When did this condition begin? _____ /_____ /_____ How did the problem start: ☐ Suddenly ☐ Gradually ☐ Post-Injury

How often does your child experience this condition? ☐ Constant ☐ Frequently ☐ Intermittent ☐ Occasionally

Activities:

Does your child play a sport? ☐ baseball ☐ basketball ☐ football ☐ hockey ☐ soccer ☐ volleyball
☐ Other: _____

Check any of the following that are affected:
☐ school ☐ exercise/sports ☐ walking ☐ playing ☐ sleep ☐ attention/focus ☐ communication ☐ eating
☐ daily routine ☐ behavior ☐ other: _____

Has your child received treatment for this condition before? ☐ No ☐ Yes
If Yes, Please Explain: _____

What makes the problem better? _____ What makes the problem worse? _____

HEALTH GOALS

What are the top two health goals for your child?
1. 2.

PREGNANCY AND DELIVERY

Please check any applicable interventions or complications:

☐ Breech ☐ Induction ☐ Pain Meds ☐ Epidural ☐ Episiotomy ☐ Vacuum Extraction ☐ Forceps

Any evidence of birth trauma? (bruises, odd shaped head stuck in birth canal, fast or excessively long birth, respiratory depression, cord around neck, other):_____

_____

PREVIOUS TREATMENT

Pediatrician: _____ Date of last visit: _____/_____ /_____

Previous Chiropractic Care: ☐ No ☐ Yes Name: _____ Date of last visit: _____/_____ /_____

Other Health Care Professional _____

Previous Diagnosis: _____

HEALTH HISTORY

Please mark any of the following conditions that your child currently experiences or has ever had:

☐ Abnormal bleeding
☐ Allergies
☐ Asthma/Wheezing
☐ Bed wetting
☐ Cancer
☐ Chicken Pox
☐ Child doesn't get along well with other children
☐ Colic
☐ Congenital heart defect
☐ Convulsions/Epilepsy
☐ Croup
☐ Dental problems
☐ Developmental problems
☐ Diabetes
☐ Diarrhea or Constipation
☐ Discipline problems
☐ Eczema/Skin Problems
☐ Emotional problems
☐ Ever eaten dirt, paint or plaster
☐ Eye problems
☐ Frequent colds or sore throats
☐ Frequent ear infections
☐ Handicaps/Disabilities
☐ Hearing problems
☐ Heart murmur
☐ Hemophilia
☐ Hepatitis
☐ High Blood Pressure
☐ High Cholesterol
☐
☐ HIV/AIDS
☐ Irritable/temper problems
☐ Kidney/Bladder problems
☐ Mouth breather/snoring
☐ Mumps, Measles
☐ Nightmares/sleep problems
☐ Night sweats
☐ Pneumonia
☐ Reflux
☐ Rheumatic Fever
☐ Speech problems
☐ TB/Lung Disease
☐ Thumb Sucking
☐ Toilet training problems
☐

Please explain any medical issues that your child has: _____

_____

Emotional Stress:

It is difficult to separate the emotional stress in our life from the physical response that often occurs. Please indicate if your child has ever or is currently experiencing any of the emotional stresses below:

☐ academic pressure ☐ loss of a loved one ☐ bullying ☐ relocation ☐ lifestyle change ☐ parents' divorce
☐ loss of a pet ☐ new sibling

Does your child have difficulty interacting with schoolmates or friends? ☐ yes ☐ no

Have you or anyone else noticed that your child is nervous, twitches, shakes, or exhibits rocking behavior? ☐ yes ☐ no

Known food sensitivities/allergies: _____

Typical diet: ☐ Mostly whole, organic foods ☐ Pretty average ☐ High amount of processed foods

Number of meals each day _____ Number of snacks per day _____

Has your child been vaccinated? ☐ No ☐ Yes If yes, which ones and list reactions to them: _____

_____

Has your child ever been on any antibiotics? ☐ No ☐ Yes How many courses: _____

List any medications, vitamins, herbs, minerals your child is currently taking: _____

_____

Please list any major illnesses, injuries, falls, auto accidents or surgeries including dates: _____

_____

How often is your child using screen time? (cell phone, ipad, computer/laptop, television) Hours per day _____