Pediatric Intake Form

Patient Information

Child's Name: _____ Child's Nickname: _____ Date: _____
Date of Birth: _____ Age: _____ Gender: M / F / _____
Street Address: _____ City/Town: _____Zip Code: _____
Pediatrician: _____ Who referred you to our office? _____
Has your child received chiropractic care? Yes / No Where? _____ Date of last visit: _____
Reason for today's visit: _____
_____
When and how did symptoms start? _____
_____
List any other doctors you have consulted for this: _____
List the date of any studies your child has had: X-Rays: _____ MRI: _____ Other:_____

Please list any medical diagnoses your child has received:

Diagnosis:	**Date/Age:**	**Comments:**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list any previous surgeries, injuries, hospitalizations, or other procedures your child has had:

Event:	**Date/Age:**	**Reason/Comments:**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list any current medications (prescription or over-the-counter) and the conditions they are being taken for:

Medication:	**Dosage:**	**Condition:**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Does your child take any vitamins/supplements? Y / N Please list:_____
_____

Parent Information:

Parent/Guardian 1 Name: _____ Relationship: _____ Phone #: _____
Parent/Guardian 2 Name: _____ Relationship: _____ Phone #: _____
Marital Status: Single / Married / Divorced / Widowed / Domestic Partnership
Other children at home? Y / N (Ages: _____)

Signature of Parent/Guardian: _____ Date: _____