T 1 2 3

pathfinder CHIROPRACTIC

Date ___/___/____

Pediatric Intake Form

It is a pleasure to welcome you to our family of happy and healthy Chiropractic practice members. Many types of stressors (physical, mental, and chemical) can interfere with your child's growing brains, spine and nervous system. To help us serve you better, please complete the following information. We look forward to working with you to build better health for your family.

Child's Name_____ Date of Birth____/_____/_____ Age_____ Male/Female

Weight_____lbs. Height_____ft._____in. Parent/ Guardian:_____

Address_____City_____State_____Zip_____

Phone: Cell _____Home _____Cellular Provider_____

Email Address_____

Who may we thank for referring you?

_____

Reason for pursuing care: ☐ Maintenance ☐ Improved Health ☐ Problem:_____

Other Doctors seen for this condition? Y/ N Doctor's names and prior treatment: _____

_____

_____

List any other health problems: _____

Family history: _____

Please Mark "P" for in the Past, OR Mark "C" for Currently Have:

____ Ear infections	____ Constipation	____ Chronic Colds	____ Headaches
____ Allergies	____ Digestive Problems	____ ADHD/ADD	____ Recurring Fevers
____ Colic	____ Growing/ Back Pain	____ Bed Wetting	____ Temper Tantrums
____ Seizures	____ Asthma	____ Car Accident: When? _____	
____ Autism	Other: _____		

Previous Chiropractic Care? Y/ N
Name of Chiropractor: _____ Last Visit: ___/___/___
Name of Pediatrician: _____ Last Visit: ___/___/___

# of Doses of Antibiotics your child has taken: Past 6 months_____ Total Lifetime _____

Present prescription drugs/ dosage? _____

Past prescription drugs/ dosage? _____

Over the counter drugs (Tylenol, Cough syrup, Laxatives, etc.) _____

Name of Obstetrician/ Midwife: _____

Complications during Pregnancy/ Delivery? Y/N If yes, explain: _____

Ultrasounds during Pregnancy? Y/N If yes, how many? _____

Medications taken during Pregnancy/ Delivery? Y/N List _____

Cigarette/ Alcohol use during Pregnancy? Y/N

Location of Birth (circle one): Hospital Birth Center Home

Birth Intervention (circle one): Forceps Vacuum Extraction Caesarian Section

If Caesarian Section, was it: _____Emergency or _____ Planned (check one)

Genetic disorders/ disabilities? Y/N List: _____

Birth Weight: _____ Birth Length: _____ APGAR Scores: _____-_____

Feeding History

Breast Fed: Y/N How long? _____ Formula Fed: Y/N How long? _____ Type: _____

Introduced to: Solid Foods @_____months Cow's milk @_____months

Food/ Juice Allergies or Intolerances: Y/N List: _____

Developmental History

Your child's spine is most vulnerable to stress and should routinely be checked by a Doctor of Chiropractic for prevention and early detection of Vertebral Subluxation (Spinal Nerve Interference).

At what **age** was your child able to:

_____ Respond to stimuli _____ Cross Crawl _____ Stand Alone

_____ Respond to visual stimuli _____ Hold Head Up _____ Walk Alone

_____ Sit up

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life. (i.e. a bed, changing table, down stairs)

Did your child have a fall similar to what was described above? Y/N Explain:_____

Has your child been involved in any sports? Y/N List: _____

Has your child been seen by a physician on an emergency basis? Y/N Explain:_____

_____

Other traumas not described above? _____

Lifestyle

Does your child: ☐ Eat health foods (organic products, etc.) ☐ Drink water

☐ Take vitamins Type: _____ ☐ Take probiotics

Exercise: ☐ None ☐ Moderate ☐ Daily ☐ Heavy

Hobbies/interests: _____

Is there anything else you would like us to know about your child? _____

Informed Consent for Chiropractic Care

Chiropractic care, like all forms of health care, while offering considerable benefits may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases, injury has been associated with Chiropractic care. The types of complications that have been reported secondary to Chiropractic care include: sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with Chiropractic care occurring at a rate between one instance per one million to one instance per two million cervical spine (neck) adjustments may be a vertebral injury that could lead to a stroke.

Prior to receiving Chiropractic care in the Chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific conditions, your overall health and in particular your spinal health. These procedures will assist us in determining if Chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

- I understand and accept that there are risks associated with Chiropractic care and give consent to the examination that the doctor deems necessary and the Chiropractic care, including spinal adjustments, as reported following my assessment.

- I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the practice member. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment.

The risks associated with exposure to ionization and spinal adjustments have been explained to me to my complete satisfaction, and I have conveyed my understanding of these risks to the Doctor. After careful consideration, I do hereby request and authorize imaging studies and Chiropractic adjustments for the benefit of my minor child for whom I have the legal right to select and authorize health care services on behalf of.

☐ Under the Terms and Conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other guardian is not required. If my authority to so select and authorize this care should change in any way, I will immediately notify this office.

Parent/ Guardian Signature: _____ Date: ___/___/____

Witness Signature: _____ Date: ___/___/____

X-Ray Authorization

As your healthcare provider, we are legally responsible for your Chiropractic records. We must maintain a record of your x-rays in our files. At your request, we will provide you with a copy of your x-rays in our files. The fee for copying your x-rays on a disc is $15. This fee must be paid in advance. Digital x-rays on a CD will be available within 72 hours of pre-payment on any regular practice hour days. Please Note**:** X-rays are utilized in this office to help locate and analyze vertebral subluxations. The Doctors of Pathfinder Chiropractic do not diagnose or treat medical conditions; however, if any abnormalities are found, we will bring it to your attention so that you can seek proper medical advice.

By signing below, you are agreeing to the above terms and conditions.

Child's Name: _____ Date of Birth: _____

Parent/ Guardian Signature: _____ Date: _____

FEMALE PRACTICE MEMBERS ONLY: To the best of my knowledge, **I BELIEVE I AM NOT PREGNANT** at the time the x-rays are taken at Pathfinder Chiropractic.

Signature: _____ Date: _____

DO NOT WRITE BELOW THIS LINE ● DO NOT WRITE BELOW THIS LINE ● DO NOT WRITE BELOW THIS LINE

Cervical Series (cm)	**Thoracic Series (cm)**	**Lumbar Series (cm)**
Lateral Cervical:	Lateral Thoracic:	Lateral Lumbar:
AP Cervical:	AP Thoracic:	AP Lumbar:
APOM:		
Flexion/Extension:		
Oblique's:		