



Gonstead Family Chiropractic

PEDIATRIC INTAKE FORM

PATIENT INFORMATION

CONFIDENTIAL

Thank you for the opportunity to serve you. If you have any questions, do not hesitate to ask. We will be happy to help.

Name _____ Date ____/____/____ S/S ____-____-____

First MI Last

Birth Date ____/____/____ Current: Height ____ Weight ____ Sex: Female Male

Parent/Guardian Name _____ Phone _____

Address _____ City _____ State ____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Who may we thank for referring you to us? _____

HEALTH HISTORY

Does your child currently have or have they previously had any of the following symptoms:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Light Sensitivity to Eyes | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Ear infections | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Ringing/ Buzzing in Ears | <input type="checkbox"/> Neck Pain |
| <input type="checkbox"/> Colic | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Upset Stomach | <input type="checkbox"/> Neck Stiffness |
| <input type="checkbox"/> Excessive Spitting up | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Constipation | <input type="checkbox"/> Mid Back Pain |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Low Back Pain |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fever | <input type="checkbox"/> Urinary Problems | <input type="checkbox"/> Arm Pain |
| <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Fainting | <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Leg Pain |
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Cold Hands |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Allergies | <input type="checkbox"/> Cold Feet |

Chief Health Concerns: _____

List other types of Care undergone for this complaint (including medications): _____

Date of onset: _____ Onset was: Sudden Gradual Associated with an event

Duration of problem (episode): _____ How often do you notice the symptoms? Constantly Frequently Occasionally

Does anything alleviate the symptoms? _____ Is the condition getting worse? No Yes

Effects of problems on body function and daily activities: _____

Was there an injury or fall? No Yes, Describe _____

Have you had x-rays before? No Yes, When? _____ What areas? _____

List any other concerns: _____

History of Birth:

Hospital Birthing Center Home Midwife Birth Weight: _____ Duration of Gestation: _____ weeks

Was the birth assisted? No Yes, if Yes: forceps vacuum c-section induced labor

Evidence of Birth Trauma? (i.e., bruises, odd shaped head, stuck in birth canal, fast or excessively long labor, respiratory depression, cord around neck) _____

Medication delivered to mother at birth? No Yes, what? _____

Duration of labor: _____ Complications at birth: No Yes, explain: _____

Growth and Development:

Was the infant alert and responsive within twelve hours of delivery? No Yes If No, Explain: _____

At what age did the child: Hold head up: _____ Sit alone: _____ Crawl: _____ Walk: _____

Do your child's sleeping patterns seem normal to you: Yes No, _____

Chemical Stressors:

Was (is) the baby breast-fed? Yes, for how long? _____ No, explain reason _____

Formula introduced at age: _____ Type of formula used: _____

Cow's milk introduced at age: _____ Began solid food at age: _____ Type: _____

Food/Juice intolerance: No Yes, type: _____

During pregnancy did the mother: Smoke? No Yes Drink Alcohol? No Yes

Supplements taken during pregnancy: _____ None

Drugs taken during pregnancy: _____ None

Any other complications during pregnancy: _____ None

Has your child received vaccinations: No Yes, which ones and reactions _____

Has your child received antibiotics: No Yes, Total courses of antibiotics to date _____

Current medications and reasons: _____ None

Surgical History: _____ None

DATE: ____/____/____ **PARENT/ GUARDIAN Signature:** _____