PEDIATRIC INTAKE FORM

Child's Name: _____ Todays Date: _____

Mother's Name: _____ Father's Name: _____

Address: _____

City: _____ State/Zip: _____

Phone: Home (____)_____ Mother's Work (____)_____ Cell (____)_____

Father's Work (____)_____ Cell (____)_____ Other _____

Primary Insurance: _____

Secondary Insurance: _____

Date of Birth _____ Birth Weight: _____ Birth Length: _____

Sex: ( ) Male ( ) Female Number of Siblings: _____

Family Medical History: (Please check all that apply and describe below)

( ) Allergy, Asthma, Eczema ( ) Cancer ( ) TB ( ) Scoliosis ( ) Ulcer
( ) High Blood Pressure/Stroke ( ) Heart Problems ( ) Liver Disease ( ) Mental illness
( ) Diabetes ( ) Hepatitis ( ) Other _____

Child's Current Medications, including frequency and dosage if know. If none check here: ( )

Medication	Start Date	Medication	Start Date
1)		3)	
2)		4)	

List any known allergies to any medications. If none, check here: ( )

1)		3)	
2)		4)	

Please describe the patient's feeding/eating history (include breast or bottle, introduction of solids, allergies): _____

_____

_____

Please describe patient's immunization history: _____

_____

Please list at what age your child was able to sit-up, crawl, stand alone, and walk alone: _____

_____

_____

Please list any history of surgery and accidents: _____

_____

Please describe any other traumas that your child has been involved in: _____

_____

Is/Has your child been involved in any high impact or contact type sports (such as Soccer, Football, Gymnastics, Cheerleading, etc.) ( ) Yes ( ) No If yes, please list: _____

_____

Has the patient ever suffered form:

( ) Dizziness	( ) Backaches	( ) Heart Trouble	( ) Chronic Earaches
( ) Diabetes	( ) TB	( ) Hypertension	( ) Colds/Flu
( ) Arthritis	( ) Headaches	( ) Asthma	( ) Allergies
( ) Neuritis	( ) Sinus Trouble	( ) Digestive Disorders	( ) Constipation
( ) Anemia	( ) Diarrhea	( ) Rheumatic Fever	( ) Orthopedic Problems
( ) Poor Appetite	( ) Hyperactivity	( ) Walking Problems	( ) Behavioral Problems
( ) Bed Wetting	( ) Convulsions	( ) Paralysis	( ) Muscle Jerking
( ) Fainting	( ) Broken Bones	( ) Ruptures/Hernias	( ) Neck Problems
( ) Arm Problems	( ) Leg Problems	( ) Growing Pains	( ) Joint Problems

Present condition/Reason for seeking chiropractic care: _____

_____

_____

Child's Primary Physician Name: _____

Physician Address: _____

_____ Physician Phone: _____

CONSENT FOR TREATMENT OF MINOR CHILD

I, being the parent or legal guardian, hereby authorize Dr. Strawberry G. Weber D.C. and whomever she may designate as assistant to administer treatment as deemed necessary to:

_____

(Name of Minor Child)

Date: _____ Signature: _____

Print Name: _____

Relationship to Patient: _____