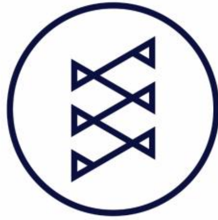


Modern Health
CHIROPRACTIC & WELLNESS

File # _______

NEW PEDIATRIC INTAKE FORM

Who can we thank for referring your child to our clinic? ______________

INFORMATION:

Name:	Age:	Date:
Address:		City/Prov./Zip:
Gender:	Date of Birth:	Birth Height & Weight:
Home Phone:	Parent Email:	
Mom's Name:	Mom's Phone:	
Dad's Name:	Dad's Phone:	
Pediatrician Name:	Last Visit:	
Reason For Visit:		
Best Way to Contact:	Best Time to Contact:	
Do you have insurance coverage? ☐ Yes ☐ No	If yes, what is the name of your insurance company?	
This plan covers _______% of chiropractic services rendered up to $_________ per year.		

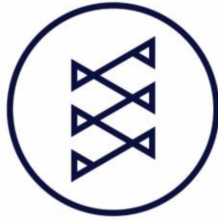
Child's Current Health Status:

The purpose of this visit is: Wellness Checkup ____ Injury or Accident ____ Other ____
Please explain: ____

Is your child experiencing pain? If yes, where and for how long? _____________________
____

When did the problem first begin? Date:_____ Unknown ____ Gradual ____ Sudden____

Has your child ever had this problem before? Yes or No If yes, when? ________________



Is your child experiencing bowel or bladder problems? Yes or No ___________________

Have you consulted other medical professionals for this problem? Yes or No pIf yes, who, how long ago and what was the result? ________________________________
____

How is this problem now? Improving ___ About the same ____ Gradually worsening ____

Has your child ever sustained an injury playing sports? ______________________________

Has your child ever sustained an injury due to an auto accident? _____________________

Please list any medication your child is taking or has taken in the past: ________________
____

Has your child been vaccinated? Yes or No

Was your child delivered by C-Section? Yes or No

Did the birth of your child have complications? Yes or No If yes, please describe:
____

Has your child ever suffered from any of the listed conditions below?
Please check all that apply.

☐ Headaches	☐ Orthopedic problems	☐ Digestive problems
☐ Dizziness	☐ Neck problems	☐ Poor appetite/ nutrition
☐ Fainting	☐ Arm problems	☐ Stomach aches
☐ Seizures	☐ Leg problems	☐ Acid reflux
☐ Heart problems	☐ Joint problems	☐ Constipation
☐ Ear infections/ earaches	☐ Backaches	☐ Diarrhea
☐ Sinus problems	☐ Anemia	☐ Frequent colds/ flus
☐ Scoliosis	☐ Colic	☐ Broken bones
☐ Behavioral problems	☐ ADD/ADHD	☐ Autism
☐ Muscle pain	☐ Hernia	☐ Asthma
☐ Sleeping problems	☐ Walking problems	☐ Bed wetting
☐ Diabetes	☐ Developmental delay	☐ Skin problems
☐ Falls (from bed, swings, crib, stairs, bicycle, couch)		
☐ Allergies to:		

"Have you more faith in a spoonful of medicine than in the power that animates the living world?" – D.D. Palmer

Doctor signature: ________________________ Date: _____________________

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