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Pediatric Intake Form (Birth to 3 years)

Date:____________
Child's Name:______________________________ DOB: ____________________
Parents/Guardians Name:____
Phone Numbers: (H)_____________(C)______________ Best to reach you? H or C
Address:____
Email Address:____
Has your child ever been to a chiropractor? YES or NO Name:__________________
Were X-rays taken? YES or NO Name of Pediatrician:____________________________
Medications: ____
Allergies:____

Prenatal History

Is your child adopted? YES or NO
Did you have any complications if so when?_____________________________________
Did you smoke or consume alcohol during pregnancy? ☐YES ☐NO
Did you take any medications during pregnancy? ☐YES ☐NO reason:___________________

Birth History:

Did you have ultrasounds during this pregnancy? ☐YES ☐NO Frequency__________________
Place of Birth: Home/ Birthing Center/ Hospital
Provider: ☐ Midwife ☐ OB/GYN ☐Other (Name)_______________________________
Type of Birth: Vaginal / Cesarean Were pain medications used? Yes/ No Type:______________
Was Labor induced? ☐YES ☐NO If yes, why?____
What position did you deliver in? ☐ Squatting ☐On Back ☐ Other________________________
Birth Trauma: ☐Doctor Assisted ☐ Twisting and/or Pulling ☐ Vacuum Extraction ☐ Forceps
Newborn Trauma (medical procedures and tests):____________________________________
APGAR score: at birth _____/10 at 5 minutes: _____/10 Unsure
Did your child have a misshaped skull/head? ☐YES ☐NO Purple Markings on their face? ☐YES ☐NO
Do you/Did you breastfeed your child? ☐YES ☐NO If yes, how long?______________________
Does your child prefer one breast/side over the other? ☐YES ☐NO Side: ☐RIGHT ☐LEFT

Does your child have any food or other allergies (list)?_________________________________
Has your child been immunized according to the recommended schedule? ☐YES ☐NO
Reason for vaccination: ☐ Informed Decision ☐Didn't know has a choice ☐ Recommended
Did your child have any negative reactions to vaccinations? ☐YES ☐NO
Has your child ever had any surgeries? ☐YES ☐ NO If yes list__________________________
Have they been on antibiotics? ☐YES ☐ NO How many times?__________ Reason?____________
Is your child currently taking any medications? ☐YES ☐NO List:_______________________
Any vitamins? ☐YES ☐NO List____