Pediatric Intake Form - Birth to 12 Years

Date: _____

Name: _____

DOB: _____ Social Security#: _____

Parent/Guardian Name(s): _____

Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ E-mail: _____

Has your child been seen by a chiropractor before? Yes / No

Has your child had X-rays taken? Yes / No If yes, what for? :_____

Who is your medical pediatrician? _____ Phone:_____

Prenatal History

Birth Weight:_____ Birth Length:_____

Type of Birth: Vaginal Breech Cesarean Other:_____

Home Birthing Center or Hospital? _____

Provider: Mid-wife OB-Gyn Other:_____

Any Medications used during Delivery? :_____

Was Labor Induced? Yes No If yes, why?:_____

Any Problems during Pregnancy and/or Labor?:

_____

_____

What position did you deliver in?:_____

Birth Trauma: Fractures Twisting and/or Pulling Vacuum Extraction Forceps

Other:_____

Jaundice (Yellow) at birth?: Yes / No Cyanosis (Blue)?: Yes / No

Birth Defects/Abnormalities: _____

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 Right / Left

Does your child have any food or other allergies? Yes / No

If yes, Please List:_____

Has your child been Immunized according to the recommended schedule? Yes / No

Did your child have any negative reactions to vaccinations? Yes / No

If yes, what: _____

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Were the negative reactions reported?: Yes / No

Has your child had any surgeries? Yes / No

Please Explain:

_____

_____

Have they been on antibiotics?: Yes / No

How many times?: _____ Reason:_____

Current Medications:

_____

_____

Current Vitamins/Supplements:

_____

_____

Any concerns with the following:

Responding to Sound: _____

Crawling: _____

Holding Head Up: _____

Standing: _____

Walking: _____

Has the child ever suffered from (please check all that apply):

- ☐ Allergies
- ☐ Asthma
- ☐ Blood Disorders
- ☐ Crying Spells
- ☐ Dizziness (Chronic)
- ☐ "Growing Pains"
- ☐ Joint Problems
- ☐ Neck
- ☐ Sinus Trouble
- ☐ Tonsillitis
- ☐ Other: _____
- ☐ Anemia
- ☐ Backaches
- ☐ Broken Bones
- ☐ Diabetes
- ☐ Earaches
- ☐ Headaches
- ☐ Leg Problems
- ☐ Problems Neuritis
- ☐ Sleeping Problems
- ☐ Tuberculosis
- ☐ Arm Problems
- ☐ Bed Wetting
- ☐ Colds/Flu
- ☐ Diarrhea
- ☐ Fainting
- ☐ Heart Trouble
- ☐ Low Weight
- ☐ Rheumatic Fever
- ☐ Stomach Aches
- ☐ Walking Problems
- ☐ Arthritis
- ☐ Behavior Problems
- ☐ Colic
- ☐ Digestive Issues
- ☐ Falls
- ☐ Hyperactivity
- ☐ Muscle Jerking
- ☐ Ruptures/Hernias
- ☐ Sugar Concentration

Relevant Family History:

_____

_____

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What brings your child in today?: _____

_____

When did it Begin?: _____

Is it getting worse?: Yes / No

Does the complaint affect daily activities?: Not at all / Somewhat / Frequently / Always

What makes it better?: _____

What makes it worse:? _____

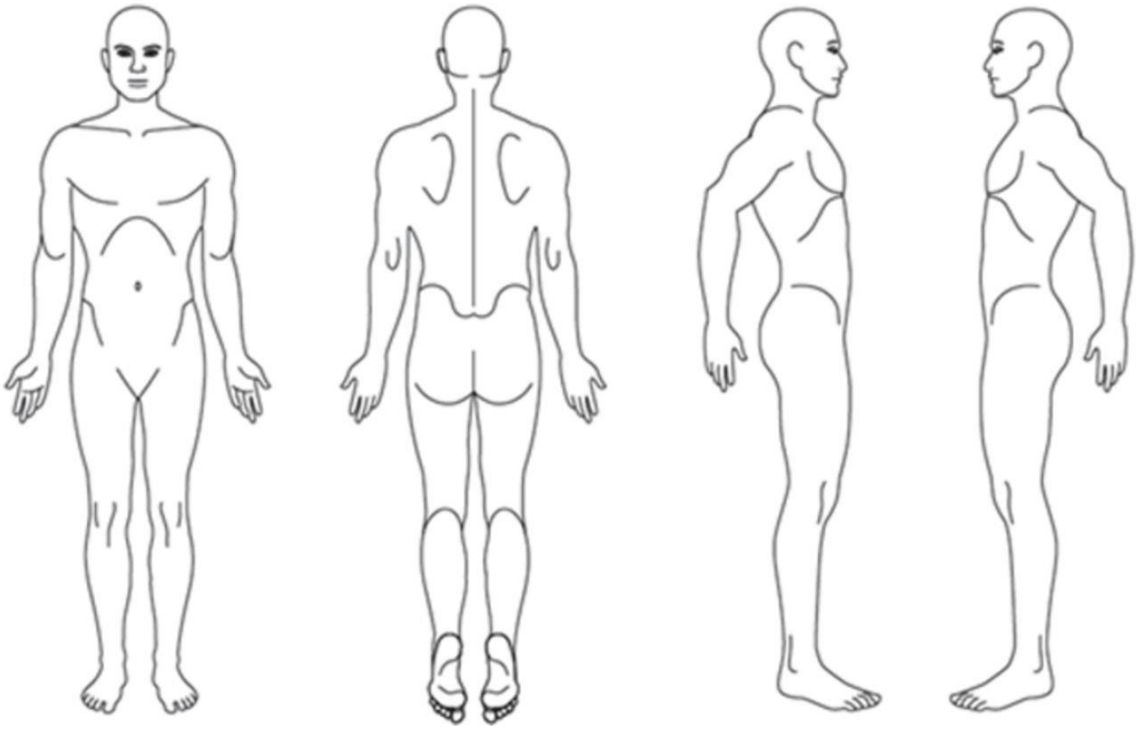
Does it happen at any specific time of day?: _____

List any other care your child has undergone with regards to this complaint, including medication:

_____

_____

Shade in area(s) of concern:



What sports does your child play?: _____

How would you rate your child's diet?: Well Balanced / Average / Poor

How much water does your child drink?: _____ glasses per day

Does your child consume artificial sweeteners?: Yes / No

Number of hours your child sleeps?: _____ Quality: Good / Fair / Poor

Any thing else we should know about your child?: _____

Authorization to Treat a Minor

I, _____ the undersigning parent/person having legal custody/guardianship of _____, a minor, do hereby authorize, request and direct Dr. Lisa Braden and whomever she may designate as assistant to perform in judgement any examination and chiropractic diagnosis or treatment which is deemed necessary.

Parent/Guardian Printed Name: _____

Signature: _____ Date: _____

Payment is due when the service is rendered.

Dr. Lisa N. Braden, D.C. is committed to the success of your chiropractic treatment and better health. Your clear understanding of our financial policy is important to our professional relationship. Blue Ribbon Chiropractic is not currently in network with any insurance plans and we do not bill to Medicare/Medicaid/TriCare. Our office currently accepts Personal Checks, VISA, MasterCard, and FSA/HSA, as well as Cash payment.

Cancellation Policy:

A 24-hour notice is required for cancelled appointments. An office visit charge of $45 will be applied to your account if any appointment is "no showed". If rescheduled prior to 24-hours of appointment, no charge will be applied to your account.

We understand that things come up and emergencies happen. However, because we block 20-30 minutes in the appointment schedule for you to meet with the doctor, this causes others with health care needs seeking treatment unable to come in when our schedule is full. As a courtesy, text message reminders are sent to remind you of your upcoming appointment. Due to the variation of cell phone plans the lack of delivery of a text reminder does not exclude you from paying the $45 fee if an appointment is missed.

I understand the above terms:

Printed Name: _____Date:_____

Signature: _____

Wittness:_____