courtley CHIROPRACTIC

Pediatric Intake Form

It is our pleasure to welcome you and your family to our practice. Please let us know if there is any way we can make you and your family feel more comfortable. To better serve you, please complete the following information. We look forward to working with you! Thank You!

Date: _____ Child's Full Name:_____

Names of parents/guardians:_____

Child Phone (if applicable): _____ Best Number for Parents:_____

Do you have other immediate household family members who are patients here? Y / N (please circle)

If yes, please list them _____

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

Sex: M / F (please circle) Weight:_____ Height:_____ Date of Birth:_____

Referred by/ How you heard about us: _____

Purpose for contacting us?_____

Other doctors seen for this condition: Y / N If yes, please list doctor's name and prior treatments: _____

_____

Check any of the following conditions your child has suffered from during the past six months:

__ Ear infections	__ Digestive problems	__ Auto Accident	__ Headaches
__ Asthma/Allergies	__ Bed Wetting	__ Chronic Colds	__ Growing/Back pains
__ Colic	__ Seizures	__ Recurring Fevers	Other: _____
__ Scoliosis	__ ADHD	__ Temper Tantrums	_____

Relevent Family History:_____

Previous / Current Pediatrician:_____ Date of Last Visit:_____ Reason:_____

Number of doses of antibiotics your child has taken:

a) During the past six months:_____

b) Total during his/her life:_____

Number of doses of other prescription medications your child has taken:

c) During the past six months:_____

d) Total during his/her life:_____

Vaccination History: _____

Feeding History (if child is older, you may move on to next section)

Breast Fed: Y/ N If yes, how long?_____ Formula: Y/ N If yes, how long:_____

Introduced to solids at _____ months. Cow's milk at _____ months. Food/juice allergies or tolerances: Y/ N

If Yes, Please List_____ Other allergies or tolerances: Y / N If Yes, please list:_____

Number of Hours Sleeping per Night: _____ Quality of Sleep: Good / Fair / Poor

Prenatal History:

Cesarean Section: Y / N If yes, planned or emergency? (please circle) Ultrasounds during pregnancy? Y / N

Medications during pregnancy/delivery? Y / N If Yes, please list them:_____

Cigarette/alcohol use during pregnancy? Y / N How much and how often? _____

Anything else we need to know?_____

Childhood Diseases:

Chicken Pox: Y / N Age:_____ Measles: Y / N Age:_____ Whooping Cough: Y / N Age:_____ Rubella: Y / N Age:____

Other: _____

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e. a bed, changing table, down stairs, etc.). Was this the case with your child? Y / N If yes, please explain:

Has your child been involved in any high impact or contact sports (i.e. football, gymnastics, baseball, cheerleading, martial arts, etc.). Y / N

I hereby authorize Courtley Chiropractic to administer care to my son/daughter, as they deem necessary. Standard fees for an initial visit in our office may total up to $250. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Please send completed form to info@courtleychiropractic.com or turn in at the desk when you arrive for your appointment.

We are here to serve you and encourage both you and your child to ask questions during your visit with us today - We are glad you are here!

Signed: _____ Relationship to Patient: _____ Date: _____

Courtley Chiropractic