

# Kids Chiropractic Intake

(11 & Under)



**PATIENT INFO**

First Name \_\_\_\_\_ MI \_\_\_\_\_ Last \_\_\_\_\_ Birth Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_  
Home # \_\_\_\_\_ Cell # \_\_\_\_\_ Email \_\_\_\_\_  
Can we send you occasional text messages for important reminders?  Yes  No  
Gender \_\_\_\_\_ # of Siblings \_\_\_\_\_ Parents Names \_\_\_\_\_  
Who may we thank for referring you to our office? \_\_\_\_\_

**HOW CAN WE HELP YOUR CHILD?**

What brings you in today?  Wellness Checkup  Other: \_\_\_\_\_  
\_\_\_\_\_  
If your child is already experiencing a symptom, what is it? \_\_\_\_\_  
\_\_\_\_\_  
How long has this condition persisted? \_\_\_\_\_  
If he/she is experiencing pain, is it:  Sharp  Dull  Comes and Goes  Travels  Constant  
Since the problem started, is it:  About the same  Getting Better  Getting Worse  
Have you seen other doctors for this condition? \_\_\_\_\_  
Name of previous chiropractor? \_\_\_\_\_  
Any additional comments? \_\_\_\_\_  
\_\_\_\_\_

**PREGNANCY**

Did you experience any of the following during your pregnancy? (Check all appropriate boxes)

Back / Other Pain  Gestational Diabetes  Hyperemesis Gravidarum  Swelling  Strep B  
 Pre-Term  Fatigue  Nausea / Vomiting  Pre / Eclampsia  Other

If other, please explain: \_\_\_\_\_  
\_\_\_\_\_

Was baby ever in breech position?  Yes  No How many ultrasounds were performed? \_\_\_\_\_

**BIRTH HISTORY**

Type of birth (check all that apply):

Home  Birthing Center  Hospital  Vaginal  Breech  
 C-Section  Scheduled / Induced  Epidural  Forceps  Vacuum

Problems during labor / delivery? \_\_\_\_\_

Antibiotics  Congenital Anomalies  Failure to Thrive  Jaundice  Meconium  
 Respiratory Distress  Extended Hospitalization  Other: \_\_\_\_\_

Infant Feeding:  Breast  Bottle  Formula

Number of hours of sleep each night: \_\_\_\_\_ Quality of Sleep: \_\_\_\_\_

At what age did the child: \_\_\_\_\_

Hold head up: \_\_\_\_\_ Sit unsupported: \_\_\_\_\_ Crawl: \_\_\_\_\_ Stand: \_\_\_\_\_ Walk unsupported: \_\_\_\_\_

Have you vaccinated your child?  No  Yes  As Scheduled  Delayed

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Has your child had any illnesses?  
List which ones: \_\_\_\_\_

Has your child ever had any of the following (check all that apply)?:

<input type="checkbox"/> ALLERGIES	<input type="checkbox"/> BROKEN BONES	<input type="checkbox"/> DELAYED SPEECH	<input type="checkbox"/> HYPERACTIVITY	<input type="checkbox"/> SINUS TROUBLE
<input type="checkbox"/> ASTHMA	<input type="checkbox"/> CHRONIC EAR ACHES	<input type="checkbox"/> DIABETES	<input type="checkbox"/> JOINT PROBLEMS	<input type="checkbox"/> WALKING PROBLEMS
<input type="checkbox"/> BED WETTING	<input type="checkbox"/> COLDS / FLU	<input type="checkbox"/> DIGESTIVE ISSUES	<input type="checkbox"/> POOR APPETITE	<input type="checkbox"/> CAR ACCIDENT
<input type="checkbox"/> BEHAVIORAL PROBLEMS	<input type="checkbox"/> COLIC	<input type="checkbox"/> HEADACHES	<input type="checkbox"/> SURGERIES	<input type="checkbox"/> SPORTS INJURIES

Allergies (Please List)	Medications (Please List)	Supplements (Please List)
_____	_____	_____
_____	_____	_____

**CONSENT TO EVALUATE AND ADJUST A MINOR CHILD**

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important each patient understands both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

**Adjustment:** An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Our philosophy involves "open-bay" adjusting. Should you have personal questions, we do have adequate space for that.

**Health:** A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

**Vertebral Subluxation:** A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

Dynamic Family Chiropractic Policies / Procedures:  
**(Please Initial Next to Each Line)**

- \_\_\_\_\_ 1. All initial services and subsequent fees are payable when services are rendered. (Co-pays, deductibles, etc.) Failure to pay will result with balances being transferred to a collection agency.
- \_\_\_\_\_ 2. I have read and understand The Notice of Privacy Act (HIPPA forms, behind New Patient Paperwork) and a copy will be provided to me if requested.
- \_\_\_\_\_ 3. I authorize Dynamic Family Chiropractic to use my child(s) photographs for education or marketing purposes.

I, \_\_\_\_\_, being the parent or legal guardian of \_\_\_\_\_, have read and fully understand the above statements and hereby grant permission for my child to receive chiropractic care.

\_\_\_\_\_ Signature

\_\_\_\_\_ Date