GARDEN STATE FAMILY CHIROPRACTIC Ages 0-5 Intake Form

As a family chiropractic office, we focus on your child's ability to be healthy. Our goals are first to address the issues that brought you to this office, and second, to offer you and your child the opportunity of improved health potential and wellness services.

Name of Patient: _____ Today's Date: _____

Date of Birth: _____ Age: ____ Male ___ Female ___ Height: _____ Weight: _____

Name of Parent #1: _____ Name of Parent #2: _____

Names & Ages of Siblings: _____

Phone number: _____ Email Address: _____

Address: _____

How did you hear of our office? _____

If your child has no symptoms or complaints, and is here for wellness services, please check here ☐

Otherwise, please use this space to briefly describe the reason for seeking chiropractic care: _____

_____

_____

Has your child ever suffered from (past or present): (Check all that apply)

☐ Feeding Issues	☐ Tongue Tie	☐ Colic	☐ Reflux
☐ Excessive Gas	☐ Tightness/body tension	☐ Sinus Congestion	☐ Asthma
☐ Torticollis	☐ Walking Problems	☐ Bed Wetting	☐ Allergies
☐ Behavioral Problems	☐ Growing Pains	☐ Frequent Colds	☐ Fussiness
☐ Developmental Delays	☐ Excessive Crying	☐ Autism/Asperger's	☐ Constipation
☐ Decreased Range of Motion	☐ Neck Pain	☐ Back Pain	☐ Scoliosis
☐ Plagiocephaly/Flattened head	☐ Arm/Leg Pain	☐ Postural Issues	☐ Joint Pain
☐ Ear Infections	☐ ADHD	☐ Fainting/Seizures	☐ Headaches

Previous Chiropractor:_____ Date of last visit: _____

Reason: _____

Name of Pediatrician:_____ Date of last visit: _____

Reason: _____

Please list all medications your child is taking: _____

Please list all supplements/vitamins your child is taking: _____

Vaccination history: _____

Number of doses of antibiotics: In the last 6 months: _____ Lifetime: _____

Dietary restrictions for your child (or for yourself if the child is breastfed):_____

_____

Prenatal & Birth History for your child:

Were there any complications or problems with the pregnancy? Y____ N____ If Yes, please describe:

_____

# of previous pregnancies: _____ Any complications with previous pregnancies:_____

Dd you use fertility medications? Y____ N____ Did you conceive through IVF? Y____ N____

Please list any medications or hospitalization taken during the pregnancy: _____

_____

Location of birth: _____ Name of Attendant: (Midwife or OB?):_____
Type of Birth: Vaginal___ VBAC___ Emergency C-Section___ Planned C-Section___ Forceps___ Vacuum___

Weeks Gestation: _____ Were you induced? Y___ N___ If yes, Why?:_____
Please list any medications taken during the birth: _____

_____

How long was the labor? _____ How long were you pushing? _____

Were there any complications during the labor/birth?:_____

Were there any complications after your child was born or were they brought to the NICU?:_____

_____

Please list any medications (including antibiotics and vaccinations) given to your child after birth: _____

_____

Birth Weight: _____ Birth Length: _____ APGAR scores: ____, ____ Discharge weight: _____

Feeding history for your child:

Breastfed? Y___ N___ If yes, for how long? _____ Complications? _____
Bottle-fed? Y___ N___ If yes, for how long? _____ Complications? _____
***If you did not breastfeed, skip this section**
Nipple pain/trauma while breastfeeding? Y___ N___
Inability to latch on or maintain latch? Y___ N___
"endless" feeds described by mom? Y___ N___
"poor milk transfer" observed by mom, a lactation consultant or your child's doctor? Y___ N___
Poor weight gain (less than 20g/day over at least 5 days) without supplementation? Y___ N___
Can your child elevate their tongue at least mid-way in the mouth with the mouth open? Y___ N___
Can your child maintain suction on mom's nipple or on a bottle nipple? Y___ N___
Can your child stick their tongue out past their gums w/o a "heart-shaped" defect of the tongue? Y___ N___
Can your child move their tongue side to side in their mouth (tongue lateralization)? Y___ N___
Does your child's tongue appear to have a white patch without white patches elsewhere? Y___ N___
Does your child's upper lip tuck under when latched? Y___ N___
Does your child have a "nursing blister" on the top lip? Y___ N___

Infancy/Toddler history for your child:

Symptoms of Colic? Y___ N___ If yes, please describe: _____

Symptoms of Reflux? Y___ N___ If yes, please describe: _____

Poor head control/low muscle tone? Y___ N___

Ear infections? Y___ N___ If yes, how many? _____ How many were treated with antibiotics? _____

Were tubes put in ears? Y___ N___ If yes, Date of surgery: _____

Sinus infections? Y___ N___ If yes, how many? _____ How many were treated with antibiotics? _____

History of Strep? Y___ N___ If yes, how many? _____ How many were treated with antibiotics? _____

Please describe your child's sleep habits: _____

_____

How often does your child have a bowel movement: _____

Please describe their stool:
____ yellow seedy mustard
____ yellow or brown peanut butter consistency
____ loose or runny
____ has slimy, green-colored streaks or glistening strings
____ chalky white
____ hard, pebble-like poop
____ formed, hard
____ formed, soft

Would you describe your child as very gassy? Y___ N___ If yes, please describe: _____

Please list any surgeries or procedures and dates: _____

_____

According to the National Safety Council, 50% of children fall head first from a high place during their first year of life (bed, changing table, couch, down the stairs, etc.) Was this the case for your child? Y___ N___

Is/Has your child been involved in sports? Y___ N___ Type(s): _____

Has your child ever been involved in a car accident? Y___ N___ Date: _____

Any other traumas not listed above or falls from over 3 feet: _____

Is there any other health information that you feel would be helpful and would like to share with the Doctors:

_____

_____

_____

WE ARE HERE TO SERVE YOU AND WE ENCOURAGE YOU TO ASK QUESTIONS. YOUR PARTICIPATION IS VITAL AND WILL HELP US DETERMINE CARE FOR YOUR CHILD.

AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize this office and its Doctors to administer care to my child as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Print: _____ Signed: _____ Date: _____