Little Five Points Chiropractic

Dr. Amy King

Pediatric Intake Form

Name_____ Date _____

Date of Birth _____ Age _____ Gender _____

Address _____ City _____ State _____ Zip _____

Parent/Guardian _____ Cell _____

Parent/Guardian _____ Cell _____

Siblings: No Yes (names/ages) _____

Pediatrician/Midwife _____

City & State _____ Last Visit _____

Reason for last visit _____

Is your child adopted? No Yes If so, at what age? _____

Birth Height: _____ Birth Weight: _____ Current Height: _____ Current Weight: _____

Has your child ever been under chiropractic care? No Yes When? _____

How did you hear about Dr. King? _____

Pregnancy History: (please circle)

Did you receive any of the following during your pregnancy? (If so, how often?)

Chiropractic Care Massage Acupuncture Energy Work Other

Did you receive an ultrasound during your pregnancy? No Yes (how many?) _____

Third Trimester Presentation: Vertex Breech Transverse Face/Brow

Type of Birth: Vaginal Cesarean Forceps Suction Cap Vacuum Induced Epidural

Did you have any problems/complications during pregnancy? Please explain.

Did you have any problems/complications during labor/delivery? Please explain.

Location: Home Birthing Center Hospital Other: _____

Who was present during birth: OBGYN Midwife Doula Chiropractor Family members

Any indication of: Jaundice (Yellow) Cyanosis (Blue) Congenital Anomalies/Defects (please list)

Infant feeding: Breast Bottle What formula? _____

Does your child prefer one breast over the other? No Yes

Please describe your child's diet. Include any dietary restrictions and/or allergies:

Number of Hours sleep per night: _____ Number of naps per day: _____

Quality of Sleep: Good Fair Poor

Where does your child sleep?

Please list all immunizations your child has received:

If your child has been immunized, did they have any reactions? No Yes (please list)

At what age did your child:

Respond to sound _____

Follow object with his/her eyes _____

Hold head up _____

Sit Alone _____

Crawl _____

Stand _____

Walk alone _____

At what age, if ever, did your child experience the following:

Chicken pox _____

Mumps _____

Measles _____

Rubella _____

Whooping Cough _____

Please list any other major illness your child has experienced:

Has your child ever been treated at the emergency room, hospitalized, or had any surgeries? If yes, please explain.

Please list any medications (prescription or OTC) that your child has taken, past or present:

Has your child ever experienced: (please circle)

Headaches	Ruptures/Hernia	Poor Posture
Low Immunity	Seizures/Convulsions	Asthma
Frequent Fevers	Leg Problems	Allergies
Orthopedic Problems	Reflux	Scoliosis
Digestive Disorders	Muscle Pain	Anemia
Behavioral Problems	Heart Trouble	Colds/Flu
Dizziness	Joint Problems	Walking Trouble
Neck Problems	Constipation	Bed Wetting
Poor Appetite	Growing Pains	Colic
ADD/ADHD	Chronic Earaches	Broken Bones
Fainting	Backaches	Sleeping Problems
Arm Problems	Diarrhea	Other: _____
Stomach Aches	Sinus Trouble	_____

Has your child ever experienced the following traumas: (please circle)

Fall in baby walker	Fall off swing	Fall down stairs
Fall from bed or couch	Fall off bicycle	Fall from changing table
Fall off skateboard or skates	Fall from high chair	Fall off monkey bars
Fall from crib	Fall off slide	Other: _____

Please list any sports that your child is involved in:

Has your child ever sustained an injury playing organized sports? If yes, please explain.

Has your child ever sustained an injury in an auto accident? If yes, please explain.

Please circle any options that pertain to your child's socialization:
Caretaker/Nanny Daycare/Preschool Homeschool Public/Private School Other
How many hours per week? _____

Will anyone other than yourself (or your partner) be bringing your child to L5P Chiropractic? No Yes
Name: _____ Relationship: _____ Cell: _____

Purpose of today's visit: Wellness Check-up Pain/Discomfort Injury Other (please explain)

If this visit is due to Pain/Discomfort/Injury:
Date of onset: _____ Unknown Gradual Sudden
Has your child ever had this problem before? No Yes (when?)

Has your child had any changes in eating habits? No Yes (describe)

Has your child had any bowel or bladder changes? No Yes (describe)

Has your child taken any medications for this issue? No Yes (please list)

Have you seen any other doctors for this issue? No Yes (please list)

I hereby authorize L5P Chiropractic and Dr. Amy King to administer care, as they so deem necessary to my child, _____.

(please print child's name)

_____ _____

Parent's or Legal Guardian's Signature Date