CONNECTED LIFE CHIROPRACTIC

Phone: 405-920-6440
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PEDIATRIC INTAKE FORM

Thank you for taking time to fill out the following forms. Our mission is to support people in their journey to optimum health, function, and well-being. Our focus will be to help bring your system into a state of balance/ease, to assist you as you become more aware, stronger, and empowered in your health, & to create supports for you to better adapt to stress and activities of daily living.

Step one in our time together is learning more about you – the whole person. We understand that health expression is multi-faceted (physical, chemical, emotional/mental). Reviewing each aspect and the stessors in each category help us paint the whole picture and decide where to go from here.

We are honored to have you here. Our team will take amazing care of you & your family!

BASICS

Legal Name: _____ Today's Date: _____

Nickname/Preferred Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Gender: ☐ Male ☐ Female

Phone: (h) _____ (c) _____ (w) _____

Email: _____

Preferred Method of Contact: ☐ Call – *Home, Cell, or Work* ☐ Text ☐ Email

Legal Guardian Name(s): _____

Who can we thank for referring you? _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Home: _____ Mobile: _____

Primary Care Physician: _____

Office Number: _____

WHAT BRINGS YOU HERE?

People seek Chiropractic/Acupuncture care for a variety of reasons depending on personal needs, expectations, perceptions, and past experiences. We want to do our best to understand so that our team can meet your specific needs. Please check those that apply to you:

RELIEF CARE

☐ Pain reduction ☐ Symptom relief
☐ Crisis Management ☐ Stress reduction

CORRECTIVE CARE

☐ Improved function ☐ Increased strength
☐ Improved movement ☐ Improved performance

HOLISTIC CARE

☐ Improved quality of life ☐ Prevention
☐ Improved immune system function
☐ Optimum nervous system function
☐ Full body integration ☐ Longevity

OTHER

_____
_____
_____

Guardian Signature: _____ Date: _____

Office Rep. Initial: _____

MAJOR FOCUS / COMPLAINT / CHALLENGE

#1 Health Goal: _____

#1 Heath Challenge: _____

Please tell us why you are here:

_____

_____

When did it start? _____

What happened? _____

What daily activity(ies) is this affecting? _____

Since onset, is this condition: ☐ Improving ☐ Worse ☐ Same

Improves with:

_____

_____

_____

Worsens with:

_____

_____

_____

PREVIOUS TREATMENT / TESTING

☐ None
☐ Chiropractor _____
☐ Medical Doctor _____
☐ Physical Therapist _____
☐ Acupuncturist _____
☐ ER/Urgent Care _____
☐ Orthopedic _____
☐ Massage _____
☐ X-rays _____
☐ MRI _____
☐ CT _____
☐ Other: _____
☐ None

HISTORY / LIFESTYLE / STRESSORS

Pregnancy History

Illnesses/Complications: _____

Medications During Pregnancy: _____

High Emotional Stress During Pregnancy? ☐ Yes ☐ No

Birth History

Labor @ _____ weeks Induced: ☐ Yes ☐ No Pitocin: ☐ Yes ☐ No

Location: ☐ Home ☐ Hospital ☐ Birth Center Interventions: ☐ Forceps ☐ Vacuum ☐ Caesarian

Birth Complications: _____ Birth Weight: _____

Guardian Signature: _____ Date: _____

Office Rep. Initial: _____

Nutrition

Breastfed: ☐ Yes ☐ No How Long? _____

Formula: ☐ Yes ☐ No Type: _____

Food allergies/intolerances? _____

Does your child eat well? ☐ Yes ☐ No Healthy Digestion? _____

Emotional/Developmental Health

Does your child sleep well? ☐ Yes ☐ No If no, please explain: _____

Is your child hitting typical age-appropriate milestones? ☐ Yes ☐ No

Is your child happy/content overall? ☐ Yes ☐ No

Physical Stress

Any significant traumas, falls, or injuries? ☐ Yes ☐ No ☐ Unsure

If yes, when and please explain important details: _____

Any hospital visits? ☐ Yes ☐ No

Have you had any surgeries, fractures or dislocations? ☐ Yes ☐ No

If yes, when and please explain important details: _____

Any major motor vehicle accidents? ☐ Yes ☐ No

If yes, when and please explain important details: _____

Are you in prolonged postures, repetitive motions, or strenuous physical stressors? ☐ Yes ☐ No ☐ Unsure

If yes, please describe: _____

Hobbies/Sports: _____

Chemical Stress

Prescription or over-the-counter medications? ☐ Yes ☐ No

If yes, please list what and why: _____

Supplements or vitamins? ☐ Yes ☐ No

If yes, please list what and why: _____

Water Intake: ☐ Well-hydrated ☐ Dehydrated

Do you eat well? *(well-balanced, nutrient-rich, fresh, organic)*

☐ Yes, always ☐ Mostly clean, work in progress ☐ Never, my diet needs to be addressed

Regular exposure to pollutants, strong odors, chemicals, or aerosols?

☐ Daily ☐ Occasional ☐ Former ☐ Never

Has your child been vaccinated? ☐ Yes ☐ No

Vaccine Plans: ☐ None ☐ Delayed Schedule ☐ Full Schedule

Guardian Signature: _____ Date: _____

Office Rep. Initial: _____

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REVIEW OF SYSTEMS

Is your child **currently** experiencing any of these symptoms? *(Please select all that apply)*

General:
- ☐ Fever
- ☐ Fatigue
- ☐ Nightmares
- ☐ Other: _____
- ☐ *None in this Category*

Musculoskeletal:
- ☐ Joint Pain/Stiffness/Swelling
- ☐ Muscle Pain/Stiffness/Spasms
- ☐ Growing Pains
- ☐ Scoliosis
- ☐ Broken Bones _____
- ☐ Other: _____
- ☐ *None in this Category*

Neurological:
- ☐ Dizziness or Lightheaded
- ☐ Convulsions or Seizures
- ☐ Tremors
- ☐ Other: _____
- ☐ *None in this Category*

Neuro/Psychiatrist: *(Mind/Stress)*
- ☐ Nervousness/Anxiety
- ☐ Depression
- ☐ Sleep Problems
- ☐ Autism
- ☐ ADHD
- ☐ Behavioral Issues
- ☐ Tics
- ☐ Other: _____
- ☐ *None in this Category*

Genitourinary:
- ☐ Frequent or Painful Urination
- ☐ Blood in Urine
- ☐ Incontinence or Bed Wetting
- ☐ Painful or Irregular Periods
- ☐ Other: _____
- ☐ *None in this Category*

Gastrointestinal:
- ☐ Loss of Appetite
- ☐ Blood in Stool or Black Stool
- ☐ Nausea or Vomiting
- ☐ Abdominal Pain
- ☐ Frequent Diarrhea
- ☐ Constipation
- ☐ Reflux
- ☐ Other: _____
- ☐ *None in this Category*

Respiratory:
- ☐ Difficulty Breathing
- ☐ Cough
- ☐ Asthma
- ☐ Other: _____
- ☐ *None in this Category*

Eyes & Vision:
- ☐ Corrected Vision
- ☐ Eye Therapy
- ☐ Other: _____
- ☐ *None in this Category*

Head, Ears, Nose & Mouth/Throat:
- ☐ Frequent/Recurrent Headaches
- ☐ Ear – Ache/Ringing/Drainage
- ☐ Hearing Loss
- ☐ Sensitivity to Loud Noises
- ☐ Sinus Problems
- ☐ Sore Throat
- ☐ Chronic Ear Infections
- ☐ Other: _____
- ☐ *None in this Category*

Hematologic & Lymphatic:
- ☐ Excessive Thirst or Urination
- ☐ Cold Extremities
- ☐ Swollen Glands
- ☐ Anemia
- ☐ Other: _____
- ☐ *None in this Category*

Integumentary: *(Skin and Nails)*
- ☐ Rash or Itching
- ☐ Change in Skin, Hair or Nails
- ☐ Eczema
- ☐ Other: _____
- ☐ *None in this Category*

Allergic/Immunologic:
- ☐ Food Allergies
- ☐ Environmental Allergies
- ☐ Other: _____
- ☐ *None in this Category*

Cardiovascular & Heart:
- ☐ Chest Pains/Tightness
- ☐ Rapid or Heartbeat Changes
- ☐ Other: _____
- ☐ *None in this Category*

- ☐ AutoImmune Dx
- ☐ Cancer

Details of AutoImmune or Cancer Diagnosis/Treatment (Type/Date/Treatment/Current Status):

_____
_____
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_____
_____

Anything Else We Should Know:

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I certify that I understand that providing a full health history is imperative for the doctor(s) to make the best plan and choices for my child's care. I affirm that I have thoroughly and honestly completed these intake forms to the best of my ability. I acknowledge that a comprehensive evaluation is necessary to determine the next steps most appropriate in this case.

Printed Name of Child: _____

Guardian Signature: _____ Date: _____

Office Rep. Initial: _____

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