Wildflower
FAMILY CHIROPRACTIC

# NPM INTAKE FORM: PEDIATRIC

## ABOUT THE CHILD:

| | | |
|---|---|---|
| Name: | Age: | Date: |
| Address: | | City/State/Zip: |
| Home Phone: | Cell Phone: | Email Address: |
| Weight: | Gender: | Date of Birth: |

## ABOUT THE PARENT:

| | | |
|---|---|---|
| Name: | Relationship to child: | Date of Birth: |
| Address: | | City/State/Zip: |
| Home Phone No.: | Work Phone No: | Cell Phone: |
| Email Address:: | Best Time to Contact: | Occupation: |
| Number of Children : | Names and Ages: | |
| Marital Status: | Additional Parent/Guardian Name(s): | |

## CHILD'S BIRTH EXPERIENCE:

| | | |
|---|---|---|
| Were there any complications in pregnancy? | Was mom on any medications, prescriptions, over-the-counter? | Did Mom or Dad smoke during pregnancy? |
| Was the baby ever in breech position? | How many ultrasounds were performed? | Where was baby born ____Hospital ____Birth Center ____Home ____Other |
| Was the delivery: ____ Vagnial ____ C-section | Were any devices used? ____ Forceps ____vacuum | How long was Labor? |
| How long was delivery? | Was oxytocin/pitocin used? | Was an epidural administered? |

## INFANCY:

| | |
|---|---|
| Was there any prolonged use of medications or an inhaler? | Did the infant suffer any traumas such as falls or car accidents? |

## CHILDHOOD YEARS:

| | |
|---|---|
| Did the child experience any childhood illnesses? | Has the child suffered any emotional traumas? |
| Does the child play sports? If so, what sports? | Has there been any prolonged use of medications? |
| Was the child involved in any car accidents? | Has the child fallen from a height over 3 ft.? |

## CHIROPRACTIC EXPERIENCE:

| | |
|---|---|
| Who referred you to our office? | Has the child or any member of you family ever seen a Chiropractor? |

## MEDICATIONS/VACCINATIONS:

| | |
|---|---|
| Number of doses of prescription medication child has taken during his/her lifetime? | Please list all medications. |
| Have you chosen to vaccinate your child? | Describe any and all reactions to vaccines. |
| Please list any supplements. | Has your child had any surgeries or hospitalizations? |

**THANKS FOR PROVIDING US WITH PIVOTAL INFORMATION THAT CAN LITERALLY CHANGE YOUR CHILD'S LIFE!**
**ON TO THE NEXT PAGE!!!**

## CHILD'S HEALTH PROFILE:

What brings you into our office?
Wellness: _____ If your child has no symptoms or concerns and are here for Chiropractic Wellness Services, please skip to the "General History" page.
If your child has a health concern please briefly describe the chief concern, including the impact it has had on your child's life.

| Health Concern: | Severity 1 = mid, 10 = worst imaginable | When did this start? |
|---|---|---|
| Are symptoms constant or intermittent? | Did the problem begin with an injury? | Since the challenge started, it is ____The Same ____Getting Better ____Getting Worse |
| What makes it worse? | What, if anything makes it feel better? | Has this condition happened before? |
| Have you seen other doctors or chiropractors for this condition? | Doctor's name: | Results: |

Because the Nervous system controls everything in your child's body, it is common that current health challenges can be related to the problems you and your child are seeking care for in our office. Please check (✓) the following symptoms your child has had, whether CURRENT (C) or PAST (P):

| | Past | Current | | Past | Current |
|---|---|---|---|---|---|
| Asthma | ☐ | ☐ | Neck stiff/pain | ☐ | ☐ |
| Bed wetting | ☐ | ☐ | Loss balance | ☐ | ☐ |
| Bronchitis | ☐ | ☐ | Tension | ☐ | ☐ |
| Constipation | ☐ | ☐ | Dizziness | ☐ | ☐ |
| Learning disorders | ☐ | ☐ | Irritability | ☐ | ☐ |
| Nervousness | ☐ | ☐ | ADHD | ☐ | ☐ |
| Migraines | ☐ | ☐ | Anxiety | ☐ | ☐ |
| Diarrhea | ☐ | ☐ | Urinary issues | ☐ | ☐ |
| Ear infection | ☐ | ☐ | Hyperactivity | ☐ | ☐ |
| Headaches | ☐ | ☐ | Arm tingling | ☐ | ☐ |
| Back pain | ☐ | ☐ | Buzz/ring in ears | ☐ | ☐ |
| Hypersensitivity | ☐ | ☐ | Numbness in fingers | ☐ | ☐ |
| Stomach upset | ☐ | ☐ | Numbness in toes | ☐ | ☐ |
| Depression | ☐ | ☐ | Sleeping problems | ☐ | ☐ |
| Cold feet | ☐ | ☐ | Autism | ☐ | ☐ |
| Fever | ☐ | ☐ | Menstrual irregularity | ☐ | ☐ |
| Menstrual Pain | ☐ | ☐ | Tingling in legs | ☐ | ☐ |
| Heartburn | ☐ | ☐ | Allergies | ☐ | ☐ |

If we have not listed current health challenges on the list above, please list additional health concerns in the lines below: _____
_____
_____

## CHILD'S GENERAL HISTORY:

It has been shown that daily lifestyle stress significantly impacts your child's overall health and wellbeing. As a family wellness office we specialize in not only removing the cause of your child's health challenges, but we also focus on teaching you and your child how to manage the lifestyle stresses that are keeping your child from reaching optimum health and wellness.

Please rate the following and circle ALL answers that apply to your Child's habits:
(1 being very poor and 10 being excellent)

**Eating habits: _____**

a. My child eats 3-5x's a day
b. My child eats fruits and vegetables daily.
c. My child eats out 2-3 times weekly (min)
d. My child drinks 3-5 sodas weekly
e. My child craves sweets.

**Exercise habits: _____**

a. My child exercises 3-5 times a week.
b. My child walks daily.
c. My child doesn't exercise.
d. I want my child to exercise.
e. My child sits 6-8 hours/day
f. My child sits 8-10 hours/day

**Sleep: _____**

a. My child sleeps 7-9 hours/night
b. My child wakes up well rested
c. My child wakes up tired.
d. My child tosses and turns.
e. My child stays up late.

**Mind Set: _____**

a. My child has a positive outlook.
b. My child has a negative outlook.
c. My child is always in a bad mood.
d. My child is always in a good mood.
e. My child traps things inside.
f. My child shares easily.

On a scale of 1-10 describe your psychological/emotional stress levels:
(1= none/ 10=extreme)
School: _____
Personal: _____

## YOU ARE ALMOST THERE!

## THANKS FOR PROVIDING US WITH INFORMATION THAT COULD HELP US TO BETTER SERVE YOUR CHILD AND HELP THEM BE THE BEST THEY CAN BE!

## GOALS

At our office we pride ourselves in helping you and your child to achieve phenomenal results with health and wellness. In order for us to truly help your child to be as healthy as possibly, it is important that we understand your goals for overall health and wellbeing for your child.
Please list your goals for your child's health and wellness in the spaces provided.

| Physical Goals | Nutritional/Biochemical Goals | Psychological Goals |
|---|---|---|
| | | |
| | | |
| | | |

If there is a need for dietary changes would you like to know? ☐ Yes ☐ No

If there is a need for specific exercises would you like to know? ☐ Yes ☐ No

If there is a need for support in the psychological, mind body, stress management dimension of health would you like assistance? ☐ Yes ☐ No

Now we just need your permission to continue through our process!

I consent to a professional and complete chiropractic examination and to any radiographic examination that the doctor deems necessary for my child. I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Parent or guardian Signature_____ Date: _____

**THANK YOU FOR FILLING OUT THIS FORM.**
**IT IS YOUR FIRST STEP TO CREATING WELLNESS FOR YOU CHILD!**
Present this to our staff and in a moment we will be starting our journey together!